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ABSTRACT

This document is a collection of essays by various authors on the subject of dance therapy. Dance therapy, in the introduction of this document, is defined as a form of psychotherapy in which the therapist utilizes movement interaction as the primary means of accomplishing therapeutic goals. The document is divided into five parts: a) "Introduction"; b) "Philosophy and Method", including essays on the role of a dance therapist in a psychiatric setting; c) "Techniques for Research and Observation"; d) "Dance for Special Groups", including minimal brain dysfunction children, the visually-impaired, the deaf, and older people; and e) "Training and Professional Status", which includes essays on curriculum development in dance therapy and a master's level inservice training program. (JA)

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DANCE THERAPY

Kathleen Criddle Mason
Editor

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Focus on Dance VII

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Preface

Dance Therapy is in a period of flux and growth. Our attempt to bring it into focus takes into consideration the kaleidoscopic base that undergirds this, as any, emerging profession. It is critically important at this point in our development that we share ideas. We dedicate *Dance Therapy: Focus on Dance VII* to the cause of continued and expanded dialogue in this most vital and exciting field.

Kathleen Criddle Mason

Part I

Introduction

Dance Therapy in Perspective

Claire Schmais

Dance therapy is a form of psychotherapy in which the therapist utilizes movement interaction as the primary means for accomplishing therapeutic goals. The dance therapist extrapolates those ingredients from dance that enable the patient to move towards healthier functioning. Movement is the medium of dance therapy just as words are the medium of verbal therapy. The therapist and patient engage in a movement dialogue creating a new dance -- a dance of health.

Dance therapy has roots that extend back to ancient times in dances of celebrations and crises, in dances that define individual and group identity, and in dances of death and exorcism.

Changes in Dance

The development of dance as therapy in America is, in part, a result of the revolutionary changes in dance. Isadora Duncan was the first to break from the stultifying structure of classical ballet and champion dance as the emanation of emotions in harmony with external forces of

the natural world. She saw dance as man's most fundamental response to the universe; reviving man's capacity to dance was the means through which his ability to live fully and freely could be renewed (20).

The early pioneers of modern dance not only cast away the tutu and the prescribed steps of ballet, but also stripped away its structure. In this way they were able to give primacy to the emotional content and begin a creative search for new ways of communicating. Without the limitations of superimposed techniques these efforts led the early modern dancer-choreographer to turn inward, to re-examine her own repertoire, especially the importance of her individual style of expression. The greater range of expressiveness and focus on total personal experience nurtured a new definition of dance, one that laid the groundwork for its use in therapy.

Mary Wigman exemplified this new view. She studied dynamics and space with Laban and eurythmics with Dalcroze. In her teaching she stressed the use of the body as an expressive instrument and focused on the need to return to one's own emotional experience in order to recreate the material of the dance.

The dance is a living language which speaks of man — an artistic message soaring above the ground of reality in order to speak, on a higher level, in images and allegories of man's innermost emotions and need for communication. It might very well be that, above all, the dance asks for direct communication without any detours. Because its bearer and intermediary is man himself, and because his instrument of expression is the human body, whose natural movement forms the material for the dance, the only material which is his own and his own to use. (25:10)

It is no accident then, that many of the leading dance therapists learned the art of dance from Wigman and her followers.

Changes in Therapy

The growth and establishment of dance therapy as a separate discipline is also a result of several convergent trends in the field of mental health. New ideas are nurtured by necessity and it was out of the experiences of World War II that a new era in mental health began. Psychiatric problems hampered the American military effort; a staggering 1¾ million men were rejected and ¾ million more men were discharged because of emotional problems (11). The extent and prevalence of mental illness shocked the nation. After the war, the country was faced with the problem of rehabilitating the returning veterans. Their disturbances were found to be more the result of the stress and crisis of the wartime experiences than their repressed sexual drives. Individual analytic therapy, based as it was on lengthy explorations into childhood trauma, was not capable of dealing with the numbers of patients nor with their types of problems. However, in a number of hospitals a newer view of psychiatry was being explored. The focus on the unconscious was being superseded by an emphasis on social concerns. Freudian theories were being expanded by the interdisciplinary collaborations of people such as Horney, Mead and Kardiner. To treat the scores of returning veterans, new approaches were being developed that could facilitate their rehabilitation, e.g., group therapy, activity therapies, art therapies and instructional groups (3, 13).

Start of Dance Therapy

One of the first institutions in which dance therapy was included as part of an ongoing treatment program was St. Elizabeths Hospital in Washington, D.C. Marian Chace, who was then teaching dance to children and adults in the Washington area, was St. Elizabeths' first dance therapist. Her approach to technique and improvisation stressed individuality and attracted many people who claimed to gain physical and emotional rewards from these classes. A number of psychiatrists at St. Elizabeths interested in developing new group approaches to treatment became aware of the therapeutic effects of these dance experiences by their private patients.

As a result, in 1942 Marian Chace was invited to work with patients at St. Elizabeths Hospital. Her background and philosophy were ideally suited for this. She had developed observational skills in her study of art and dance. She had a knowledge of anatomical principles from studying with Bess Mesendick. She learned about other cultures in her extensive study of ethnic dance at the Denishawn School. She understood the process of development from years of teaching children of all ages. Most importantly, she knew the dance from 25 years of teaching, performing and choreographing. Through her efforts, dance therapy became an important aspect of patient care at St. Elizabeths.

During the 50s, greater community responsibility and the discovery of tranquilizers led to important changes in the treatment of patients in institutions. Many chronic backward patients could now be released from restraints, and as a result, were approachable. Drastic medical measures such as insulin, electric shock or surgery were no longer the only solutions. Since many of these long-term patients did not speak, nonverbal techniques, such as dance therapy, were needed to reach and reactivate them. During this period, dance therapists started moving with patients who had been physically and emotionally isolated.

Two major developments in the 60s — the human relations training movement and resurgence of research in non verbal communication — brought an even greater interest in dance therapy as a treatment modality. Human relations trainees found that exercises involving body movement led to heightened awareness of themselves and others, increased their ability to express, affect, and engage in more empathic relationships. Movement experience became highly valued in developing sensitivity and reducing defensive behavior.

In the area of research, the works of Birdwhistell (1) revived the interest in body motion. Based on a structural linguistic model, he developed "kinesics," a method of analyzing the communicative behavior of the human body. While Birdwhistell concentrated on looking at body movement as it accompanied speech, some researchers looked at other variables such as spacing, postural movement, facial expression, eye contact, and shadow movements as part of the process of human interaction. This research had particular importance for dance therapy, since interaction through movement is a primary concern in dance therapy practice. For example, the research on

synchrony in human communication helped to clarify an important part of the process of dance therapy — the need to develop a common rhythm in order to reestablish communication (6).

In the fall of 1964, a small group of dance therapists who studied with Marian Chace met in Washington to discuss the formation of a dance therapy association. In 1966, 73 charter members formed the American Dance Therapy Association. Their goals were to set professional standards and to establish channels of communication among dance therapists who mostly were working in isolation in hospitals and clinics throughout the country.

Now, in the 70s, as a tribute to the growth of dance therapy, there are over 500 members in the American Dance Therapy Association. This growth is matched by the development of new forms of dance therapy training. Universities for the first time are beginning to offer degrees in dance therapy. Hospitals and clinics are offering in-service training to aspiring dance therapists.

Dance therapy today is not limited to hospitals, but plays an important part in community mental health programs that try to provide patients with the necessary social skills and corrective emotional experiences to keep them in the community or to enable them to return to the community. Dance therapists are also working in special schools, clinics, prisons, rehabilitation centers, nursing homes, etc., where they participate with other professionals to bring about the healthy functioning of the very young to the very old.

Psychoanalytic Influences

The way in which many dance therapists work reflects specific psychoanalytic influences. I will briefly discuss the works of Reich, Jung and Sullivan because they focus attention on three issues that are essential to the practices of dance therapy — the expressive language of the body, the therapeutic value of artistic experience and the interactive nature of personality.

Reich was very aware of the expressive movements of his patients. Not only was he concerned with what the patient said, but he was equally concerned with what was revealed in how he moved. According to Reich, the way a patient walked, stood, and breathed was analogous to his specific character type. For example, he describes the movements of an hysteric as primarily soft, sequential, agile, and labile, whereas the compulsive's movements are highly tense, uneven, rigid and restrained (22).

Reich theorized that defenses were rooted in the body as chronic muscular tension. He states that "Every increase of muscular tonus in the direction of rigidity indicates that a vegetative excitation, anxiety, or sexuality has become bound up . . . " (22:343). He considered that tension in specific body parts relates to the resolution of conflicts by the repression of basic effects. For example, "holding" in the chest area is considered indicative of repressed feelings of needing and longing.

These views coincided with what many dance therapists saw as one of their functions — to help the patient reduce muscular tension (what Reich calls the "defensive armor") so that basic mobility could be regained. Therapists found that engaging the patient in movement patterns specifically designed to mobilize the chronically held areas allowed for the expression of repressed excitation and affect (4, 9, 23).

Jung's work gave credence to the use of art as a means by which the patient could become an object to himself. He viewed the artistic experience, or what he called "active imagination," as having both a diagnostic and therapeutic function. The creative act evokes material that is available for analysis and is at the same time cathartic. By virtue of the nonliteral or apparently nonrational aspects of the creative act, deep feelings that defy words can be symbolically represented. Both conscious and unconscious material can be given structure and form (14). The Bender and Boas study of patients in Bellevue also supported Jung's position (2). They found that the primitive nature of spontaneous dance had within it the potential of stimulating and giving expression to primitive unconscious fantasies as well as helping patients deal with their conflicts through the creative act. Fantasy thus becomes imbued with an element of reality which allows the patient to reflect on his own creations.

Mary Whitehouse, a dance therapist in California, finds this theme of C.G. Jung's in her practice. She describes some passages of body movement as Active Imagination in sensory terms ("the flow of unconscious material coming out in physical form") (12:40). She enables the patient to deal with his feelings and fantasies as they gradually unfold as movement sequences.

Sullivan's interpersonal theory of personality had a major effect on the development of dance therapy. He described personality as "the relatively enduring patterns of recurrent interpersonal situations which characterized a human life" (24:111). The neonate becomes transformed into a person by virtue of his experience. Sullivan describes experience very specifically as "the inner component of events in which an organism participates . . . anything lived or undergone . . . " (24:26). The experience differs from the event itself — it is rather the perception of the event. And at each major stage in development the child has a different mode of perceiving his surroundings.[1]

Personality is developed through the accumulated experiencing of self in an interpersonal environment. An individual not only develops particular characteristics as a result of his interaction, but he also develops a sense of self, the ability to become an object to himself — to reflect on his own perceptions of self, and to react to himself as he would expect others to react to him.

Dance therapists influenced by Sullivan view dance therapy as a process of resocialization vis-à-vis the interactive process. For example, Chace describes the beginning of dance therapy sessions as follows:

The movements used in establishing initial contact with a patient may be qualitatively similar to those of the patient (not an exact mimicking, since this is often construed by the patient as mocking) or they may be expressive of an

[1]Sullivan describes three states of perception. The prototaxic mode is the momentary undifferentiated states of infancy; the parataxic mode is things accidentally occurring together; and the syntaxic mode occurs when meaning is consensually validated (pp. 28-29).

entirely different emotion with which the therapist has responded to the patient's gestures. (4:221)

The therapist consciously structures the movement interaction as both a reflection of and response to the patient's presentation. She is sensitive to minute change in behavior and modifies her movements to support and encourage the patient's development. Chace summarizes the patient's involvement in the following way:

His meaningful, though bizarre movements become understandable and acceptable to others as people relate themselves to him on the basis of the emotions expressed through dance action. As his feeling of isolation and his fear of a lack of understanding are reduced, he is able to put aside autistic expression to an increasing degree, and this in turn seems to enable him to enter a group and function within it in a manner that is satisfying both to the patient himself, and to others in the group. (4:225)

Another major influence on dance therapy practice was the work of dancer-architect Rudolf Laban (17). He devised a system of analyzing and describing movement behavior. His method of symbolically representing the dynamic and spatial aspects of movement could be applied to both functional and expressive behavior. Dance therapists who studied Laban's system found that it helped them to observe and record the movement process of a dance therapy session. Learning to understand the harmonious relationships between the dynamic and spatial elements of movement helped them choose the movement sequences most effective in achieving treatment goals.

This method also allowed the therapist to make diagnostic evaluations in movement terms and to speak about patient behavior without resorting to the jargon of other disciplines. For example, Marion North describes what happens during the completion of a movement analysis:

. . . the synthesis begins to take shape; those aspects of movement which are particularly significant and revealing of the child become the central idea or core of ideas and other implications cluster around this centre. For instance, the central aspects of one child might be his divided and noncoordinated attitudes; his lack of ability to relate to his body center; and the reduced quality of most of his effort actions. For another, his main aspects might be his inturned body attitude of withdrawal; the exaggerated quality of his effort combinations, which lack transitions and ability to externalise. The features of another child might be poise and balance; good transitions from one movement to another and sensitive liveliness. (21:43-44)

Other assessments based on Laban's principles have been devised by Martha Davis, a psychologist, for looking at the hospitalized patient (7); Beth Kalish, a dance therapist, to observe children's movement patterns (15); and Judy Kestenberg, a child analyst, connecting movement patterns to Anna Freud's developmental concepts(16).

Major Assumptions Concerning Dance Therapy Practice

I would now like to postulate three major assumptions concerning the practice of dance therapy.

1. Movement reflects personality.
2. The relationship established between the therapist and patient through movement supports and enables behavioral change.
3. Significant changes occur on the movement level that can affect total functioning.

A basic premise underlying the practice of dance therapy is that the visible movement behavior of individuals is analogous to their intrapsychic dynamics. There is no dichotomy between the workings of the mind and the behavior of the body. The dance therapist deals with the total personality as it is expressed in body movement. How people feel or how they repress and restrict feelings is visible in the movement. Bodies become sculpted by life experiences — actions, reactions and interactions. How we move is an amalgam of our hereditary make-up and our experiences as part of a family, a culture and an environment. How we move reflects how we were touched as infants, how much freedom we were allowed as toddlers, the games we played, the friends we played with, the work we've done, the people we loved, the roles we played, and the stresses and strains we faced. Our patterns also reflect what we have learned and what we have learned to hide.

Healthy functioning implies adaptive behavior. Given a work or social task, one should be able to use the appropriate combination of dynamic elements and body parts in the necessary area of space. Many psychotics, for example, lack these characteristics. Their movements tend to be distorted, fragmented, reduced dynamically, limited spatially and often inappropriate (in other words, "bizarre"). They often are synchronous neither with self nor with others; they do not effectively satisfy the requirements of a work or social situation.

The second assumption relates to the nature of the interaction in the dance therapy process. In the dance therapy

sessions the therapist simultaneously reflects and responds to the patients' movements. She does not merely imitate the patients' movements, but she takes the role of the patient (through empathy) and attempts to invest in her movements the same feeling tone observed in the patient. As children, one way we learned who we were was by experiencing ourselves through the reactions of others. The therapist is consciously recapitulating that very same process. By emulating the patient's behavior, the therapist tries to deepen the patient's awareness of himself. Through this mirroring of movement, the patient is provided feedback about himself — what is and what is possible. To be able to reflect the variety of patient behavior, the therapist must have a wide movement repertoire unburdened by stylistic eccentricities or habitual mannerisms. She also needs a wide emotional range, one unhampered by her own fears, anger, depression, anxiety, etc.

The process of dance therapy is, however, not merely reflective, it involves the creation of a dance. This dance having the movements of the patient as the theme is then varied and developed by the therapist. These movements as created out of needs, dreams, conflicts and fantasies are neither everyday gestures nor the "virtual" gestures of the dance performance. They are in a range between the two, between the iconic and the symbolic gesture. The therapist makes a choice on how to enhance — intensify — transform the movements based on the patients' needs, providing a mirror to help the patient experience when the movement is fragmented and where it is integrated. She is at times a codancer, a director, a catalyst — suggesting, reflecting and applauding.

The third assumption concerns changes in movement behavior. As a result of the therapeutic movement process, significant changes occur. Patients learn to see themselves differently. Changes occur in their body image (5). The act of moving together literally mobilizes people. The energy released tends to reduce fragmentation, to diminish defenses and to permit the integration of feelings, thoughts and actions. Changes often occur in movement before they occur in other areas (19).

Through the movement interaction repressed feelings become crystallized into actions which lead to insights and provide the basis for interactions. Patients become aware of not only what they must and can do but also how they can do it and with whom.

Basic Characteristics of Dance Therapy

On the basis of the preceding three assumptions, I believe the basic characteristics of dance therapy to be:

1. Dance therapy is expressive. Feelings of guilt, overdependency and loneliness can be too overwhelming to put into verbal terms but they are expressed in the movement. In dance therapy the shared expression of these feelings between therapist and patients can prevent further withdrawal into isolation. According to Dyrud:

an hour of dance exercises preceding a therapeutic hour may have as dramatic an effect on the patient's capacity to express himself as the most potent antidepressant drug. (10, 17, 18)

2. Dance therapy is developmental, starting at the patient's physical and emotional level and providing experiences that foster growth and extension of self.
3. Dance therapy is physically integrative. It helps to reestablish patterns of motility, reduce fragmentation, reduce constrictions and eliminate bizarre gestures. By helping to produce integrated patterns of moving, it serves to enhance the body image and to develop a sense of identity.
4. Dance therapy is inclusive. It deals with either individuals or groups, with verbal or nonverbal patients, on the ward or in the community. It is applicable to different age groupings (children, adolescents, adults, geriatrics) and to different diagnostic categories. It can be practiced with different populations: children, adults, geriatrics, the handicapped, addicted, neurotically impaired, retarded, neurotic, psychotic, etc. For example, dance therapy has been found extremely useful in work with autistic children. Dratman describes a dance therapist's work with an autistic child as follows:

She takes the child where she finds him and tries to become one with him. She mirrors and imitates what he

does until the child is comfortable with her — and she attempts to be his body double — with all his disturbances and his withdrawal — his autism. She practices blendsmanship, to coin a phrase. Then slowly she changes just one part of the child's movements. She attempts to become part of the space and rhythm around him. Where he ends and she starts he doesn't know and after many weeks or months she slowly disentangles herself — very slowly and hopefully. Gradually he recognizes her as an entity, sees where he begins and she starts. (8:44)

Besides the vital contribution to patient health, dance therapy has an important role to play in the therapeutic community. The dance therapist can sensitize members of the entire staff to their own movement behavior and the movement of the patient. Staff can become aware of how they approach patients, how they respond and are responded to, how they touch and how others react to their touch. It provides the staff with additional evaluative material. The awareness of body movement can add to the knowledge about patients. It can reflect conflicts, defenses, and repressed emotions. The movement patterns may support or contradict the verbal behavior and in some instances can anticipate later verbalizations or actions (18). This understanding of movement behavior can serve as a barometer of change for the individual as well as for the entire community. Because we all "move," it can cut across all populations, age categories, language and cultural differences, and varying socioeconomic levels. An entire psychiatric ward can participate, i.e., all levels of staff, psychiatrists to aides, and the total patient population (the regressed, the acting out, and the withdrawn) can equally share this common experience.

Dance therapy can make an important contribution to the growing field of research in movement behavior. Because a dance therapist must develop observational skills to practice his craft, he can be an important part of a research team. Knowledge of movement behavior is essential in the development of diagnostic procedures, in recording and measuring patient change, and in comprehending communicational systems.

The profession of dance therapy is no longer in its infancy. We now have to take responsibility for developing theoretical models and for proving the efficacy of dance therapy as a treatment modality. To insure the quality of treatment, we must develop dialogues with the other arts in therapy, and with psychotherapists interested in body motion.

Finally, we should not neglect the role we can play in prevention of mental illness. From our experiences working with movement, we should help parents and teachers determine the kinds of movement experiences that will afford children an opportunity to become healthy, creative, productive adults.

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Philosophy and Method

Part II

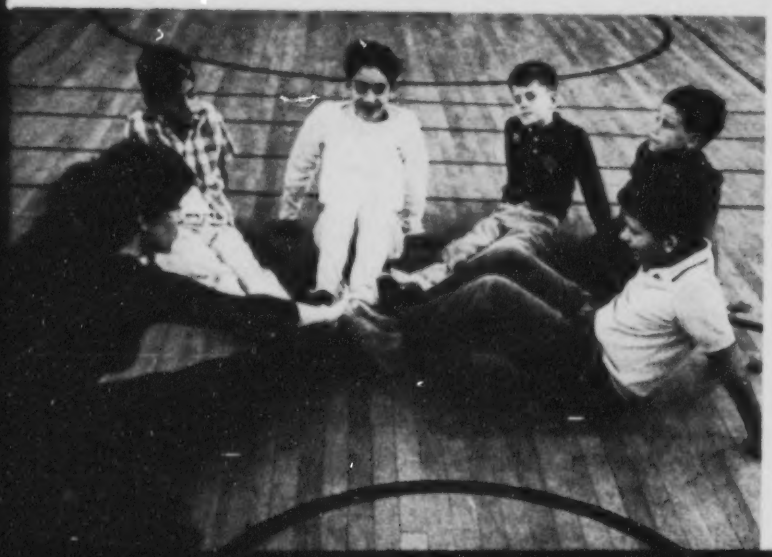
The Role of a Dance Therapist in a Psychiatric Setting

Miriam Roskin Berger

The dance therapist in a psychiatric setting has three broad categories of responsibility: training other hospital staff and students; working with patients, in groups and individually; doing movement observation and research. In large hospitals where there is a sizable dance therapy staff, there are the additional functions of supervision and administration. These functions can be fulfilled in various ways depending on the setting, taking into account the needs of the particular institution and the attitudes of its staff.

Training

The first task of a dance therapist is to educate the staff she will be working with; very often this starts even before she has a job. In the current situation it is almost always necessary for the dance therapist to convince an institution that it needs her services. Part of being a professional involves being able to communicate and conceptualize so that others can learn. The dance therapist therefore must be familiar with the literature on the efficacy of dance therapy for all sorts of populations and she must be prepared with a theoretical framework to support the use of dance and movement as therapy.



Conceptualization is needed within two large areas: the relation of movement to personality and psychopathology, and the movement analogs of psychotherapeutic processes. There are dance therapists who predicate their work on Freudian or neo-Freudian theories, in terms of both the etiology of personality and analytic processes. Others find themselves aligned with Gestalt psychology, transactional analysis, effort-shape theories of movement or Sullivanian interpersonal theories. Some establish a rationale for themselves from an eclectic base, with an emphasis on dance as a re-creative force. It is important for a dance therapist to understand various clinical approaches and to know when each is appropriate.

Once in a clinical setting, especially if that setting has never used dance therapy before, the therapist should be prepared to orient the immediate staff, using an actual movement session. In this way staff members experience movement therapy themselves and will better understand what they are prescribing for the patients. Through this orientation the dance therapist can also demonstrate the reasons for having staff present at her sessions if she so desires. The presence of staff gives the patients the sense that the staff supports dance therapy and also heightens the energy level of the group.

Once she is part of the treatment community, the dance therapist may be called upon to train various groups of personnel in the therapeutic use of dance and movement. She will be called upon to do orientations, through both movement and verbal sessions, for groups within her institution. If not asked to do this, she should initiate the idea of working with new staff in their regular training programs and with any student group such as student nurses that may receive training. Even one session will do much to acquaint new staff and nursing and medical students with dance therapy. If a particular group, such as psychiatric residents, is available for a longer period of time, a program of movement sessions might be set up for them for their own movement experience. This could help sensitize them to the benefits of dance therapy for their current and future patients. Other ongoing training might

involve activities therapists or paraprofessionals who are interested in running their own modified sessions with patients or who will be assisting a dance therapist. This can be done through regular teaching sessions or in small group supervision. It must always be kept in mind that even after the completion of a training program of this sort the dance therapist should remain available for continued supervision of the staff she has trained, to insure continued insight and enthusiasm and to be supportive of their changing needs. Goals for this sort of training should be kept very clear in terms of the kinds of movement sessions these trainees might be expected to lead once on their own, since most of these people have not had extensive backgrounds in dance and movement.

The therapist may be called upon to do more intense training of dance therapy students, either on a graduate or undergraduate level. She may have students doing field work as part of an independent study project or as a way of becoming acquainted with the field. This latter type of training has an important place, but does not require the structure of supervision needed for students in an academic degree or certificate program. Undergraduate students working in a psychiatric facility for a limited time should work in sessions only with a staff dance therapist. Trainees in a certificate program or graduate students doing an internship will be expected to assume responsibility for their own sessions under supervision. Any dance therapist who is involved with training students should remember her own feelings and reactions when she began to work as a therapist and realize that these students will experience initial anxiety about the actual work they do with patients and in their adjustment to working with other staff.

Working With Patients

In many psychiatric settings treatment is planned and dispensed through a therapeutic team system. This team usually consists of a psychiatrist, a psychologist, a social worker, an activities therapist, nursing staff, mental health aides and perhaps a dance, art or music therapist. Very often the dance or other art therapist is the only staff member who is not full-time on a particular team, which makes integration into the life of the ward or clinic especially hard.

As part of a therapeutic team, the therapist will participate in program planning for a group of patients. Her opinions will be asked on total treatment plans, case presentations, differential diagnosis and discharge plans. She will help to decide if dance or movement therapy is appropriate for a particular patient. Ideally, she should be able to function as a movement therapist on several levels within a program. Working with large groups, for example, may only be beneficial when done for short periods for a specific purpose, such as a prelude to a large therapeutic community meeting. It can be used in this way to get the staff and patients to move together, thereby establishing greater cohesiveness and relaxation and promoting the verbal interaction that is very often frozen in large groups. Large group sessions are also important for general mobilization of energy and for a positive experience of moving together. It should be emphasized, however, that the recognition of the patient as an individual is one of the most important aspects of therapy. This sense of individuality is very often diluted for participants in large groups and even in smaller ones. The therapist should establish for herself the size of the group she feels will best meet the needs of the patients.

In smaller groups, the therapist has the opportunity to create a situation in which deeper therapeutic processes can develop on movement and verbal levels: expression and awareness of feelings, experience of new ways of moving and expansion of movement possibilities, interaction of movement and words, insight into the way one moves and its effect on others. The more the therapist not only picks up movement from the patient but also actively elicits his complete involvement in the group process, the richer the therapeutic situation. No matter how structured or unstructured the particular therapist's approach, an important goal should be the continual initiation and building of interaction, expression and new experience. Sessions then constitute an organic process rather than being mechanical or imitative movement experiences.

In many new psychiatric settings therapists are expected to work with groups of heterogeneous patients — acute and chronic, old and young. This has its advantages and disadvantages. It is beneficial in that the healthier patients may provide more energy and a wider repertoire of movement behavior and may be able to give more to the group. At the same time, the therapist may not be able to work to the fullest with this kind of patient because her attention must also be focused on the more regressed patient. She will have to balance needs and therefore work on a simpler level. If it is logistically possible, therefore, it is better to work with relatively homogeneous groups. It should be remembered that not all therapists can work equally well with all types of groups, and that different approaches are needed. A movement session with adolescents might have totally different components and elicit different reactions from one with adults. Realistically, however, the hardest thing a therapist may have to do is work with a very mixed group, and she will have to find a way of doing it that has meaning for the participants.

Working in movement with individuals or with small groups of two or three patients is also an important function of a dance therapist, and should be done with close contact or supervision by the other primary therapists. Candidates for individual movement therapy might be: a patient who knows that movement is important for his functioning and senses its therapeutic meaning; a very regressed nonverbal patient who barely moves at all; a patient with a physical disability; a mother who needs help in changing her movement behavior in relation to her child. Dyadic or triadic therapeutic sessions might be appropriate when certain familial conflicts have to be brought out or worked through. Sometimes the dance therapist may work with one patient and another staff member who takes on a particular role; sometimes she may work with two patients who have complementary needs. Every so often there may be a patient who responds to nothing but movement.

Another interesting role a dance therapist might fulfill within a psychiatric setting is as a special therapist within a crisis situation. If there is an acting-out patient who must be subdued, the dance therapist can help through movement, and can also reassure and calm down other patients who might be upset by the incident. If a death occurs on a ward, movement can often be an important way of allowing the group members to express their fear, their sorrow, their need for comfort.

It may be appropriate for some sessions to include a therapist who then leads a verbal session immediately following the movement. Movement is not always enough; it is often very important for patients to have help in verbally expressing their feelings about what happened to them in movement. (And many times movement *is* enough. There are feelings that can never be translated into words.)

The therapist has to establish some process by which what happens in movement sessions is fed back to the rest of the staff in a helpful way. This can be done through several routes — written reports, rating scales, verbal reports at regular staff meetings. Communication with other therapists is vital, for dance therapists may easily fall into the pattern of coming onto a ward, doing their sessions and fading away. Some structured liaison must be set up with other staff members, no matter how limited the time may be. The therapist should be able to present a profile of the movement with which the patient feels comfortable, and she should be able to report on the changes or processes taking place on a movement and emotional level. She may also help in predicting behavior of a violent or suicidal nature if she is aware of how these tendencies are expressed in movement. Change is very often seen in movement before it appears in any other way.

Research

Research is one of the most important responsibilities of a dance therapist in any setting, and perhaps the most difficult to fulfill. It is hard to maintain the structure and discipline for research when expending energy in a therapeutic situation, and especially when working alone. Research, ideally, should be done in conjunction with other dance therapists or other clinical staff. Since research usually involves some sort of observation of movement, more than one observer is required to establish reliability. Planning of a research design should be done as carefully as possible, but therapists should not be afraid to undertake their own explorations because they feel they must do something momentous. The classic form of an experimental design, with hypothesis and controls, is not the only valid path to valuable information or knowledge. Careful observation of just one individual over a period of time can yield important data. Videotapes and films can be of enormous help in such work. This "natural history" method can supply the material from which systems can be extrapolated and from which theoretical models and hypotheses can be developed. More ambitious research set up along experimental lines is also needed, of course, to investigate such areas as the effect of short term intensive movement therapy, results of dance therapy with different populations, the differences in process and change with different movement approaches, the effect of drugs on movement response and the types of therapy with which dance works most effectively.

It is extremely important for dance therapists to do research. The lack of published material hinders complete professional recognition of our field. Interest and work in dance therapy has grown with incredible rapidity over the past decade, intensifying the need for a body of solid research which would enhance recognition of our profession by other disciplines and thus result in more structured professional opportunities and improved treatment programs. When this research is undertaken, a balance must be achieved between scientific method and the understanding that we are working with a complexity of human variables.

Administration

At some point, especially in large hospitals, a dance therapist will be called upon to do administrative or supervisory work with other dance therapists or therapists in related fields. One of the most difficult adjustments she may face is juggling her role as an administrator or supervisor with her role as a clinician. In large institutions with large staffs this may not always be feasible in terms of time and, more importantly, emotional energy. A supervisor has to be available at all times to assist the staff in problems that occur in staff relationships and in work with patients. She is responsible for planning programs and for coordinating dance therapy with other disciplines. Running a department involves providing for the exchange of ideas and feelings so that dance therapists can help each other. If time allows, movement sessions for staff can be a source of energy; a therapist who is constantly giving out needs to be nourished as well.

An administrator will be expected to keep the staff of her facility informed on the functions of her department, and to provide outside consultants as a continuing educational process for the entire hospital. She will be expected to attend staff meetings throughout the institution as necessary, act as consultant on research in her department and become familiar with the entire maze of problems involving budgets and equipment for the maintenance of dance therapy. The hiring of staff will be her responsibility, perhaps not only in dance therapy but in related fields as well. Her staff will look to her for information about personnel policies and career opportunities within the facility and for guidance through the confusing web of institutional bureaucracy.

Conclusion

The scope of a dance therapist's responsibility outlined here is modeled on a program in a large state institution, but all of its aspects may be expected of a dance therapist in any psychiatric setting to a greater or lesser degree. Large in-patient treatment centers may very likely become extinct within the next decade, with more and more psychiatric services available in community mental health centers to an out-patient population. Dance therapists will have to expand their work with short-term patients in these centers and work closely with staff involved in vocational rehabilitation. More attention will also be paid to chronic patients who have been hospitalized for many years, in an

attempt to help them achieve a self-sufficient level of functioning within a sheltered environment, and dance therapists can play an important role in this.

As the lines between mental patients and the community become more blurred, not only dance therapy but dance in *all* its therapeutic, re-creative, educational, theatrical and aesthetic aspects will have a part in enriching and sustaining the emotional health of the total community. The role of a dance therapist will expand even further into work with groups of people who are not patients in the old sense. In all her roles, a dance therapist's first responsibility is caring about movement and its relationship to life and caring deeply about the people with whom she moves.

The Dance Therapist's Role in a Clinical Team

Wynelle Delaney

Many dance therapists work in isolation within their institutional settings or agencies. It can be a lonely experience that pulls heavily on personal dedication and belief in the value of dance therapy. A challenging new role emerges when the dance therapist becomes a participating member of a treatment, rehabilitation or educational team.[1] Team membership is a rightful place for the dance therapist, but it is also a privilege that carries with it professional responsibility. It requires of the dance therapist sufficient training, skill, experience and knowledge in her own specialized area of work. She must be able to contribute intelligently and effectively to the planning of patient treatment as well as provide the rest of the team with special and ongoing orientation to the concepts and practice of dance therapy.

With today's stress on flexible and eclectic approaches to treatment, the dance therapist faces demanding but rewarding challenges. There are multiple combinations of patient populations that could benefit from dance therapy sessions. Treatment teams have their own identities, expectations and approaches to treatment within different institutional settings and community agencies. Excluding for the moment reference to research, training or orientation programs, the dance therapist is most likely to experience the major portion of her work in intake-evaluation, on-going treatment and termination of the treatment.

Team Evaluation Experiences

With her knowledge of the use of nonverbal communication and understanding of movement observation, the dance therapist is a valuable member of the team for intake and evaluation of patients. Other team members' impressions about the patient may be confirmed in body-action experiences during the movement evaluation session. Characteristics about the patient which elude other diagnostic and evaluation approaches are sometimes picked up as well. Many times, less-disguised expressive behavior is manifested by the patient during the first few movement sessions, while he is still unfamiliar with team members and the surrounding setting. After admission, the patient's subtle communicative movements sometimes seem to change as he quickly accommodates to his relationship with the staff, to the setting and to program experiences. Recordings of early evaluation movement sessions provide important check points for planning treatment goals and evaluating progress. Later, dance therapy sessions are sometimes the first place the patient begins to work, openly revealing his masked-over inner urges and their behavioral reflections.

Another type of team evaluation experience is in Multiple Impact Therapy (MIT) sessions. Various team members, the patient, his full family constellation and any

[1] See pp. 14-17, "The Role of a Dance Therapist In a Psychiatric Setting" by Miriam Roskin Berger.

other people who are regularly influential in his life meet in intense, hours-long sessions. MIT meetings can be used for diagnostic work-up prior to admission, for a closer look at the patient and his family soon after admission, or perhaps again later when there seems to be a need for everyone to get together to take stock. Evaluation sessions in movement with various combinations of family members are highly revealing of the different family members' relationships with each other. Their nonverbal communication in body action often points up factors in interrelationships that do not emerge elsewhere. Recommendations for further movement or dance therapy sessions for certain family members can come from these MIT meetings.

Types of Dance Therapy Sessions

The types of dance therapy sessions during ongoing treatment programs are highly varied. The most common session is with the patient only, as part of his total treatment program, providing continuing therapeutic experiences in that particular form of therapy. When possible, the sessions are tailored to his needs through team management and planning. At times individual sessions seem most needed; at other times group sessions will work best or a combination of individual and group sessions may be recommended. Such arrangements and accommodations for the patient are kept flexible and pertinent through constant reporting and communication between team members on both a formal and an informal basis.

Psychotherapy sessions with the patient may be enhanced by incorporating movement sessions into part of the regularly scheduled psychotherapy time. Patients who seem to resist talking, or who are unable to talk, or who will not relate to the psychotherapist through traditional verbal or other adjunct approaches, will usually change as they come to know the psychotherapist within the arena of rhythmic action and expressive movement. The full session or only part of it may be used for movement. This might be done on a temporary or on a long-term basis depending upon the needs of the patient and his relationship with the psychotherapist. Some psychotherapists feel the breakthrough in relating earlier than others; sometimes they simply decide to continue dance therapy on a long-term basis in order to use part of the therapy time for dance (either together or not) and part for talking afterward.

The art therapist and the dance therapist may work closely together. There are times when the art therapist feels the patient becomes more or differently productive if there has been a session with the dance therapist prior to working with art media. Sometimes the movement sessions emerge from the art work initiated prior to meeting with the dance therapist. Other times, art and dance therapists combine their sessions, merging the art and movement experiences.

The psychiatric social worker or other family therapist may recommend special movement sessions for members of the patient's family. As mentioned before, after MIT sessions the team may sense the need for dance or other adjunct therapies for some of the family members. Sibling therapy may be used for preventive measures with younger sisters and brothers. Older siblings may come to movement sessions for many of the same treatment needs as the patient or for special ones of their own. One or both parents may meet with their psychotherapist and the dance therapist to work on their relationship as adults through movement. The team may feel the child would benefit from his parents' experiencing dance therapy sessions with him. This area is unexplored for the most part and offers a wide variety of treatment goals. The sessions might be used simply to provide a place where parents and child can relate to each other in body-action experiences not usually possible in other settings. Or the sessions could be an arena for the parents to learn ways of relating to the child and other members of the family in their own family setting after leaving the treatment arena. Videotaping of family dance therapy sessions can be used psychotherapeutically by the social worker or family therapist when viewing replays of the family sessions with the parents.

Group psychotherapists sometimes request dance therapy sessions before or after group psychotherapy sessions either as a means of stimulating interaction and verbal exchange during the psychotherapy session or as a means of working afterward directly with the tensions produced during the psychotherapy session. Other times adult groups may meet to work specifically on exercise and relaxation experiences that tend to enhance their concepts of their own bodies.

When the patient's ongoing treatment program is in the process of terminating, the team may feel dance therapy sessions should continue as a liaison and supportive measure between the fuller treatment program that is gradually being diminished and the patient's return to community activities. The movement sessions afford the patient opportunity for expressive release in full body action of his fears and anxieties as well as providing him a time to return to a familiar, safe and supportive arena.

Values of Dance Therapy

As with other modes of treatment, if dance therapy sessions have provided the patient opportunities for experiencing initiative, confidence-building relationships, creative and flexible approaches to problem solving, increased awareness and ways of consciously getting in touch with his own inner urges and responses to the world around him, then he will carry with him tools which will always be available to him. He will have gained an independence and self-acceptance that can add to his own inner strength and identity.

Dance therapy, like other specific modalities of therapy, is no panacea. When wisely used by a trained dance therapist as an integral part of a total treatment program it has far-reaching value. The dance therapist plays a valuable role in a team approach to treatment, rehabilitation or prevention through her ability to establish authentic therapeutic relationships with patients, her ability to transmit her knowledge skillfully to team members, and the treatment team's sophistication and willingness to use the dance therapist to her fullest potential.

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Movement as Group Therapy in the Psychiatric Hospital

Caroline Lewis Burton

The goal of all forms of therapy provided in a psychiatric hospital is to alter behavior from that which is experienced or labeled as "sick" to that which is regarded as "normal." To do so, change must take place in the individual: his self-concept, the meaning of particular external objects, his goals and values or the methods he uses to reach these goals. The patient must experience interpersonal relationships which have significant personal meaning for him in order to produce change in his perception of himself and others (6).

In the hospital setting interactions occur in one-to-one therapy, in groups led by therapists and in exchanges between patients in the hospital community. The most significant interactions in terms of personal meaning are probably those generated spontaneously by patients (7). However, in the hospital, the learning which encourages meaningful communication between individuals usually occurs in therapy groups, primarily because of

the old things we have learned about man's need for social interaction, validation from others, the powerful effect of group values and norms and their ability to override individual "self-oriented neurotic needs" . . . (23:855)

Group Therapy

The variety of roles which individuals assume in groups and the ways they perceive themselves can reveal more

about both their intrapsychic defense patterns and their areas of personal strength than does individual therapy. The group appears to be a safer place, more conducive to individual risk taking (22), where the power of the therapist is somewhat diminished. The group can break through individual isolation and, through peer judgment, alter misconceptions about human feelings and behavior. In the group the patient can observe the destructive dynamics of others—resistance, blocking, confusion and denial—and test his own projections and distortions. The group is a place to begin to play roles differently and to translate understanding directly into action, to feel the gradual change in self-image as it is mirrored in others' reactions. It provides the opportunity to give as well as to receive in relationships.

Thus, in a group, a tangible social reality is always present. The therapeutic process moves back and forth between this social reality and patient's inner emotional life. Here we have a basis for continuous impact between the patient's image of interpersonal relations and their actual nature as perceived and interpreted in the group interaction. (1:255)

In order for the group to function therapeutically, the level of tension must be great enough to mobilize the patient's anxiety to work toward solutions, but not so great as to force him back into maladaptive patterns. The first tasks with a hospitalized patient are to reduce the level of anxiety so that he can begin to function and to strengthen his self-esteem so that he has the courage to begin to risk change. Initially, group therapy is sometimes more anxiety-provoking than is supportive, individual therapy. There are patients who cannot handle the type of group which leads to conscious, intellectual insight through direct probing and confrontation.

Insight therapy is the treatment of choice for many psychotics. But quite a few already have too much insight in the sense that they cannot cope with the urges and feelings of which they are aware. (9:457)

However, most hospitalized patients can tolerate activity groups which aim at change through doing as well as understanding, without stress upon exploring negative feelings and the requirement of a high degree of intellectual skill. Also, differences in culturally determined norms and values are less divisive in activity groups.

When working with a group it is important to understand and utilize the group's inherent dynamics. In the hospital it is not usually necessary to "make something happen," as the room is already filled with strong relationships and conflicts resulting from interactions in other groups and in the therapeutic community. It is important to observe what is happening as the group assembles (3:61-75) to be aware of its basic assumptions (4). Hospitalized patients usually try to form dependent groups, relating solely to the therapist for a magical cure, but fight and flight dynamics and pairing also occur, or groups may attempt to establish cohesion by focusing on complaints about the hospital rules and staff.

If the therapist begins by commenting on the apparent dynamic of the group, when there is enough evidence to support the observation, and on her own feelings, these basic assumptions and initial carry-over feelings may be utilized therapeutically. She should never ignore important events (interruptions, exits, absenteeism, late arrivals, individual distress, change of leadership) in order to move on with a planned agenda. Resistance in a group may be multidirectional, aimed at others in the group as well as at the therapist. The leader needs to be aware of all manifestations of resistance as they occur and her own identification with and resistance to some individuals in the group. Patients with a strong investment in the group may be instrumental in dealing with another's resistance, but they can also drive the frightened individual out in order to move on with the activity.

A hospital group is always an open group, with new members entering each session. The goal of the group should be to be group-centered, with primary leadership responsibility in the hands of the patients rather than the therapist. Both the open structure and the therapeutic desirability of a group-centered approach make dealing with resistance a continual, complex concern for the therapist. Direct intervention, if it occurs too frequently, may tend to encourage a dependent, therapist-centered orientation (4).

Movement Therapy

The concepts presented thus far are usually emphasized in verbal groups but are sometimes ignored by dance therapists. Early writings on dance therapy refer to such goals as physical activity, social interaction, group rhythmic activity, emotional release and relating to others (5, 19:15). All of these are valid purposes, which, however, may be accomplished through a wide variety of activities: sports, games, folk dance, music, drama. There is also a special quality to dance movement which Langer refers to as the "magic circle"; this has to do with the illusionary quality and experience of gesture in dance and the enhanced sense of personal strength and identity resulting from participation in group rhythmic activity (14:188-207). This quality of the dance experience cannot be underrated, particularly when dealing with individuals who have lost a sense of personal identity, relationship to others and physical well-being. However, by thinking in terms of a kind of group which explores movement, rather than just dance, drama or sports activities, a type of therapy can be developed which is more than just a group therapeutic activity. Within the group, movement may be explored on many levels: pure motor action (the muscle group being used and the relationship between the action of agonist and antagonist muscles), the implications of postural shifts and gestures, understanding the patient's symbolic use of time and space and object relationships, and patterns of energy. The movement may be read at whatever level of abstraction it is performed, taking both "virtual meaning" (14:188-207) and concrete information about body image, physical ability to move, range and choices as potentially significant sources of information about the individual.

Movement therapy can focus on areas of nonverbal communication which are often either superficially considered or totally ignored in verbal group therapy.

When words are removed we have more time to direct our thoughts to observing our own on-going behavior, as well as the on-going actions of others. . . Whole new realms of observables which were there all the time, become more apparent and are therefore subject to examination. (8:2)

It may be intuitively surmised, and experience bears it out, that in the long run the destiny of the individual will be more likely determined by the systems which control his facial expressions and his gesture than by the one which puts his sentences together. (3:69)

Individuals who have learned effective verbal defenses, from silence to intellectualization, need new methods of communication. Movement responses, which involve a lower brain level and are less a part of conscious awareness, are more reliable expressions of feelings than words.

There is evidence to support the conclusion that in our culture where a heavy burden of defenses are carried by verbalization, it is motor behavior that is most effective in breaking through the verbal defenses. (11:111)

It is also true that people use motor tension, particularly in the white, fine coordination muscles, to block awareness of threatening external stimuli or internal fantasies and memories. Movement utilizing postural reflexes such as walking, swinging, and swaying tends to relax these distal muscle groups and overcome blocking. There are patients whose own defense mechanisms have forced them to regress to this level of communication.

Regression, therefore, implies the use of a language the emotional impact of which is universally understood—often even by animals. Once people have established contact on this basis, the foundations have been laid for a later return to a more rational form of communication. (20:46)

The major sign of a functioning individual with adequate ego strength is his ability to decide and to take action upon the strength of decision.

The body of information which corresponds to the ego has its roots in action. . . If, however, the two kinds of information—superego- and ego-derived—point to different solutions, decision-making becomes difficult. (20:46)

Movement tasks are designed to develop a tendency toward action and decision-making ability through the exploration of contrasts (fast-slow, near-far, weak-strong, leading-following, with-against). "The capacity to express contrast may be an index of ego strength" (2:433). These tasks also reveal the patient's resistance, confusion and hidden feelings, so that he gains insight as well as relearning.

Emotion is not felt until one accepts the corresponding bodily-behavior. (16:408)

In therapy, the aim is to shift the "inner conflict" that is between impulse and counterattacking resistance, into an open, aware conflict. (16:59)

As the patient begins to move, to act, he can learn to observe his own functioning and to take responsibility for it. "To observe yourself in action—ultimately, to observe yourself as action. . ." (16:3)

Movement therapy is not only a form of action therapy but, because movement exists only in present experiencing, it is also by definition a here and now, experiential approach. After exercises in relaxation and body awareness, the patient moves, experiencing the self through the kinesethetic and tactile senses and the awareness of internal responses to objects and individuals in the environment.

Therapeutic communication. . . is designed to enable the patient to experience fully, to accept what he has experienced and to share these experiences with others. (20:37)

Once the patient has accepted the fact that he has to handle each current event on the spot, his thinking will become geared to problem solving. The unfaltering acceptance of what exists at the moment leads to the acceptance of memories that bear upon painful events of the past. . . (20:38)

Movement also emphasizes awareness of what others are really doing, rather than saying, which is the actual basis of our attitudes toward them. The tasks provided are designed not only to facilitate action and awareness, but to offer experiences which the individual might not otherwise allow himself.

. . . we must help the patient to make decisions which are based upon probabilities derived from his own experience. In some instances, the values taken over from the parent may prevent the patient from exposing himself to vital experiences which are necessary for his own development. (20:47)

The Insight-Oriented Movement Group

The movement therapy group for patients capable of applying intellectual insight gained through awareness is structured as a group-centered, open group. However, the patients are assigned to the group, and there is a contract with the leader either to attend or to be reassigned to a different activity. The goals for the group are defined and stated by the leader, and the patients' individual needs and goals are also defined.

This type of group is not appropriate for all patients in the hospital. Patients who are just beginning to regain contact with reality but who are still delusional and hallucinating actively are too threatened by their recent experience of total loss of contact to trust their own spontaneous responses; folk dance, rhythmic exercises and highly structured movement tasks are appropriate for these individuals. Patients should be assigned to groups not primarily by diagnostic categories, but by individual needs, interests, goals and the way individuals in the group may be expected to interact. However, obsessive-compulsive personalities, rigid neurotics or ambulatory schizophrenics who are unable to play or respond in a broad range, suicidal patients with a feeling of loss of self or sense of emptiness and individuals with evident body image problems may have a particular need for movement therapy.

There are specific kinds of individuals or problems which cannot be handled in the group, if the group is to remain group-centered and dynamic. Patients with specific body image problems which are related more to developmental lacks in movement exploration than to deficiencies in interpersonal experiencing, those who need a great deal of support to begin to move because of extreme insecurity and shame related to the body, and those who cannot yet relate to a group all may need individual movement therapy. The therapist may design individual tasks within the group, particularly where she can involve others in related roles, but she must weigh a decision to do so against the effect this will have on the group as a whole. Finally, patients are less autonomous in a group because they are under the influence of the whole group as well as the therapist, but they tend to deny less of what they do.

Therefore, the therapist who decides to lead a group must be prepared to abandon certain areas of exploration in order to work with the group as a whole. The leader establishes a relationship with the personality of the group as well as the individuals within it. She provides a model of openness and honesty about herself, encouraging the patients to share observations and feelings. The leader attempts to facilitate the patient's understanding of his problems in behavioral rather than symptomatic terms. She establishes a nonthreatening yet real environment by assuring the patients that they are expected not to perform but to move honestly, including stillness.

The patient's trust in the leader is a major determinant of his level of involvement. He needs constant reassurance of the leader's ability to handle any feelings or interactions which might arise, responding to the patients' immediate needs rather than to her own goals for the group. Patients then learn that the time to come to the group is when they are upset, rather than avoiding the group because of their own parental, achievement-oriented disapproval of their present level of functioning. Nevertheless, the therapist must be aware of not only the positive goals for the patient but also the patient's unconscious agenda; the patient may be attempting to prove his hopelessness. The therapist must also be aware of her own possible need for approval from the group or of a wish to appear omniscient, resolving all issues raised in the session instead of allowing the patients to experience anxiety, express hostility and grapple with problems.

The therapist offers experiences. She can share and empathize with the patient's experiencing, but she cannot have the experience. The patient must come to see himself as the agent of his own actions and perceptions. The therapist is a real other person, as well as the subject of projections and transference behavior. The therapist must distinguish between these and react honestly.

Improvisation—The Exploration of Symbolic Meaning

The main activity which goes on in the group, besides relaxation and awareness exercises, structured movement tasks and verbalization, is spontaneous movement. The goal of this improvisational activity is to get at what may be called: conscious regression in the service of the ego (12), play, getting in touch with the child (3), spontaneity, or preconscious exploration (13). This ability is a prerequisite to problem solving, decision making and creativity. It provides a means of reaching feelings and internal cues for action. However, it is important for the patient to learn to distinguish this from acting out.

Acting out will occur in the group, but it can be used to move the patient toward conscious awareness and action based upon feeling.

Here a patient deals with conflict by projecting it into a relationship; he lives it out with the other person. In this manner, inner conflict is translated into outer conflict with another person. It is this "acting out" in relationship which enhances the motor discharge of emotional tension. In this setting, the therapist can work with the irrational elements of conflict. . . in those forms which are projected onto the social scene. (1:257)

I think it is better to act out in a group where there are some rational witnesses, than to act out on the outside, where no observers can challenge the patient's distorted perceptions as he reports them to the analyst. (24:106)

In the group, tasks may be set to structure experience in new ways which tend to interrupt habitual patterns; thus, acting out, when it occurs, is more apparent to the group members. Patients observe and comment on each other's movement behavior. Movement therapy with adults must include this emphasis upon responsibility and verbal validation of the nonverbal experiences.

Excessive acting out regresses the adult ego to the prepuberty level or even farther. That's what—in psychoanalysis—we consider as antitherapeutic. (10:117)

Patients learn to understand their own acting out by understanding the transference meaning of the motor act. The goal is to bring unconscious transference into conscious awareness so that they can learn to use improvisational, symbolic relationships in an exploratory, conscious fashion.

. . . as the motor act becomes more closely associated with an awareness of the transference nature of his behavior, the patient acquires increasing control over his previously blind behavior. The perception of the transference image then takes precedence over the motor act and the patient is thereby able to act upon his feelings. (11:110)

The motor response may be dysfunctional without being psychopathological.

If the behavior or action is not based on an unresolved transference, then it is acting or reacting to be experienced and examined in the light of its constructiveness and destructiveness for self and others. (2:433)

Patients explore both the transference and nontransference elements of symbolic meanings through spontaneous improvisations, in order to learn more about themselves and others and to begin to get in touch with their own inner cues as the impetus to act. It is this lack of inner-directedness which produces the sensation of emptiness and loneliness to which patients so often refer (18:50). They dislike themselves because they contrast their present behavior with their idealized self-concept. They lack a sense of identity and disapprove of all impulses not appropriate to this ideal. They become immobilized. One must be able to face a multiplicity of choices in order to

decide to act. If anxiety blocks access to preconscious material because the individual cannot tolerate risking contact with repressed impulses, there is no action.

> ... *whenever we allow our thoughts to roam without a preselected goal, this process of automatic preconscious selecting and rejecting remains relatively inactive, exposing ... the influences arising from "unconscious" fear, guilt, hate, purpose and conflict.* (13:57)

The leader reduces the threat inherent in exploration through verbal cues which focus attention and establish a goal.

The patient needs to discover his own "intentionality"—what he really wants to do—which requires contact with feelings and the ability to take a stand toward an object (15). Tensions in the body, cues which the patient can feel, are the key to getting in touch with one's own motivation to act. The body uses "a language of intentionality" and "it communicates it through movement (15:241). Patients often need to learn to tolerate their immobility, their inability to feel an authentic impulse to move, before they can find this energy of intent.

Ultimately the patient can acquire the will to take a stand. Children discover will as they learn to say no at age two to four. Patients often need to reacquire this feeling of autonomy in relation to particular objects or individuals. The various symptoms of depersonalization (loss of contact, feeling of distance, loss of body boundaries, loss of physical sensation in body parts) tend to disappear as the individual regains the will to act based upon his own intentionality and perception of feelings.

The actual experience in the session should become real for the patient. This reality is based upon the individual's high level of involvement and his ability to claim his behavior. This is less anxiety-provoking than may be expected because of the effect of the "aesthetic illusion" resulting from the symbolic use of movement. "... a firm belief in the 'reality of play' can coexist with a certainty that it is play only" (12:42). The group can be divided, using the audience effect to reinforce the concept of illusion with responsibility. Normally, psychotic art lacks this concern for audience; psychotics tend to merge themselves with the artistic expression so that it is not based upon ego-integrative, conscious forming (12:229-238, 21).

Patients often attempt to see the improvisations as only games in order to deny their meaning. However, the behavior is real; patients need to learn, see and accept the feelings they communicate to others and, particularly, the ways they elicit rejecting responses from others. They need not take the blame for another's projections or distorted responses. Patients are given permission to act upon their own withdrawal needs or to express hostile feelings as long as they stay within the experience and claim their behavior. Thus they begin to perceive their own actions, with an understanding of the feelings which triggered them, and to relate these to their past experiences and their present situations outside to what is happening in the hospital. Ultimately, they begin to change that behavior which does not work for them and to reveal a broader, more subtly appropriate range of response. The goal is the adult level of cognitive function which, according to Piaget, requires "the achievement of complete mobility and reversibility" (17:291). This provides them with the capacity to learn to fulfill their own present, adult needs.

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Philosophy and Methods of Individual Work

Joan Smallwood

The foundation of individual work in dance therapy is a one-to-one relationship growing in an ambiance of trust. Such a base is common to many therapeutic experiences and is in no way unique to dance therapy. It is critical, however, as little growth can happen without it.

In the beginning, all we have is two people, therapist and patient, who meet in a predictable place at regular time intervals. The patient may bring to these meetings a history of relationships where he had to falsify his feelings in order to be accepted. The tragedy, of course, is that even if he succeeded in winning approval he couldn't receive it. The approval was not for himself but for his facade, and therefore he was always left with nothing. It is from interactions with his therapist and others that the patient will begin to feel safe enough to learn, perhaps for the first time, to show himself as he really is.

The importance of the relationship between therapist and patient cannot be overemphasized, as it is the difference between teaching dance and doing dance therapy. There is no question that a good teacher is therapeutic (the word means "to serve, take care of"), as is a good mother, a good friend or beautiful surroundings. However, the teacher tends to focus on the material or techniques to be taught whereas the therapist gives his major attention to the patient. Mary Whitehouse described the change in herself as follows: "It was an important day when I discovered that I did not teach Dance, I taught People. It indicated a possibility that my primary interest might have to do with process not results, that it might not be art I was after but another kind of human development."[1]

Individual vs. Group Sessions

A patient might start with individual dance therapy sessions because he feels too threatened or too exposed in a group; or because he is only comfortable in a one-to-one relationship; or because he is so withdrawn or so aggressive that he is literally unable to function in a group; or because certain material has come up in psychotherapy that needs to be explored or specifically worked with in movement.

On the other hand, another patient might choose to start with group dance therapy because he feels apprehensive about the intensity of individual work; or because for him a group means safety and anonymity; or because group work is available to him and he cannot afford the cost of individual work; or because he has worked in individual psychotherapy and his therapist feels that he can now best benefit from a group experience. Beyond these there are many other possibilities in numerous combinations.

The First Approach: Structuring

Within the individual dance therapy session I generally find myself using one of two approaches, although at times

[1]Mary Whitehouse. Reflections on a metamorphosis. *Impulse*, 1969-70.

I may use both within the same session. In the first approach I assess the patient's movement repertoire and set definite goals regarding the patient's potential range of response. For example, if I see that the patient is restricted to weak movement, shallow breathing and an overall quality that might be described as monotone, I will use any technique available to help that person go beyond his present boundaries. I might use structured movement or breathing exercises that concentrate on contrasting uses of time, space and energy qualities, or we might together recapitulate the entire sequence of normal development in movement, from infancy through adulthood, emphasizing and repeating whatever he didn't get enough of. We might work with fantasy and imagery ("be a striking fork of lightning," "be a powerful giant monster"), or work with dance-drama and pantomime to help the patient express some of his own feelings, especially those that may have "shut down." This patient may need especially to express such feelings as attacking anger, bursting joy or quivering anticipation.

Ethnic forms that emphasize specific body parts can be particularly helpful to bring alive "dead" parts of the body. One patient worked for months on the strongly grounded heelwork of Spanish dance techniques, and I recently spent four or five full sessions teaching a woman the undulating pelvic-centered movements of the belly dance. The interpersonal aspect of this involves my validation of the patient's new and often threatening experience. The woman's pelvis was locked because as a child she was given the message that sensual and sexual feelings were bad and never to be felt, much less enjoyed. I taught her how to move sensually, both seriously and for the fun of it. In every way—through words and touch and movement and voice and feeling—I was able to convey to her a different message from the one she had learned as a child. She was able to receive it and eventually to delight in her own good sensations and feelings.

The more structure I use, the more the interactions between myself and the patient take on the qualities of a caring parent-child relationship. This can be critically important for the patient whose parents never took the trouble to teach him anything. A very disturbed patient once told me (as I corrected her at the ballet barre), "If my mother had made me do things this way, I wouldn't be sick now." Such highly structured sessions might include studies of basic rhythms, ballet and contemporary dance technique or ethnic dance forms.

With this structured approach much of my energy goes into planning and motivating, as I'm usually trying to evoke a specific response. This approach deals with increasing the patient's conscious awareness of himself and others, his range of movement possibilities and his corresponding feeling experiences. Most of such movement is planned, but often the planned movement is designed to contact deep feelings and at that point it becomes unplanned and spontaneous.

The Second Approach: Authentic Response

This spontaneous break from planned into unplanned movement leads us to the second approach. Here the external structure is barely perceptible and my motivating leadership role will change to one of participant or observer.

This approach is harder to describe because it involves listening to and dealing with the less known parts of our psyche—the preconscious and that which Jung described as the unconscious. This kind of work takes people into a deep self-sensing awareness that is clearly a state of consciousness markedly different from experiencing oneself and relating to others in everyday situations. The movement response is unplanned, authentic and deeply satisfying.

To illustrate this, I'm thinking of a young woman, an outpatient, who came into the studio one day feeling hyperactive and uncomfortable. We went into stretching and yawning as a warmup and then I asked her simply to take any position and "listen" and allow herself to move whichever way she needed to move. We used no music as I wanted her to rely only on inner cues. She started moving many different ways, with no apparent sense to it, nor did she allow a rhythmic momentum to build. Something would start and then she'd cut it off and then something else would start. Gradually, though, her movement began to integrate spontaneously with her breathing and her attention focused in on the moment to moment process of what she was doing. Her air shapes, which at first were sporadic and unformed, became defined and by the end she was moving slowly and purposefully, creating a space for herself. At the very end, she was sitting on the floor, legs folded, spine easily stretched upwards, as she made smaller and smaller circles with the top of her head, using the base of her spine as a fulcrum. These last movements were very subtle and very centered; she was breathing easily and looked marvelously peaceful and grounded. When she opened her eyes, she had a string of insights that included a realization that the hyperactivity was her mask for a very real need to assert herself positively in her interactions with others — to metaphorically claim her own space.

Another patient recently experienced this type of work for the first time. It was toward the end of our fifth session together. I asked if she could contrast two aspects of herself—outgoing and withdrawn. In the past, she had felt that she could not, but this day she agreed. In choosing music for her withdrawn self, she described "slow and depressed and dreary" and we used the final theme of the score from the film *Charley*. She started lying on the

ground, waiting, just listening to the music. When she started to move, it looked as if everything she did was a tremendous effort, as if each limb and her head and trunk weighed hundreds of pounds. She was deeply involved in the experience, which lasted about three minutes, and the feeling was of overwhelming sadness and resignation. . .it was very, very real. As the music stopped she started to sob very softly and I held her and rocked her for a long time. This woman had been in years of therapy but had not allowed herself to cry before.

Closing one's eyes facilitates entry into such inner worlds. When we're asleep we dream spontaneously, but we can also learn to dip into that same stuff of which dreams are made and allow its emergence in movement. The unconscious manifests itself in many ways, including dreams, primary process type urges and psychosomatic symptoms, but it also, if allowed, manifests itself continually and at all times in the way we move. There is a stream of movement impulses available to each person all the time. The impulse to move in this manner comes when one can let go of all conscious control and identify with oneself as perceived through sensations and images. An impulse might lead to movement that takes only a few moments to unfold, but a sequence of impulses, or self-directed authentic movement, can go on for a very long time.

Sometimes authentic movement is preceded by random activity and fragmented gestures. This seemingly aimless movement may go on for some time before one begins to notice a clarification and increasing sense of definition and purpose. From here, a development toward some form of resolution or release can occur, usually resulting in new experiences and insights. I've seen the process described above completed in minutes, or it may be spread over weeks or months. The release may be cathartic in nature, discharging and subsequently assimilating old, previously dissociated feelings. Or it may be a quietly gentle experience of centering, of discovering a condition of harmony between inner feelings and outer expression. Whether it is intense or gentle, I believe that authentic movement ultimately leads towards integration of the personality.

The Two Approaches

The first of the two approaches described depends on the therapist to provide the goals and the structure. Specific forms are introduced to help the patient make connections to his unexpressed feelings and to help him internalize a sense of order. When I'm working with patients who are psychotic, I use this approach exclusively. I suspect that even inside a psychotic person there is some kernel of innate order, but it is a difficult task to help him sort out and get in touch with it when he may feel surrounded and overwhelmed by inner chaos.

The second approach depends more on the presence of a stronger internal structure. In fact, it draws almost entirely from the patient himself, trusting in his innate integrity to lead the way. It is usually especially exciting and satisfying to a patient who has functioned efficiently in the outside world but feels his life and relationships to be empty, mechanical and meaningless. Somehow, this internally generated action can put people in touch with the vastness of their full potential.

I've separated my way of working into two such distinct approaches for purposes of clarification. In reality there is often a constant interchange, an ebb and flow back and forth between the two. When working within the boundaries of the first approach I keep constant feelers out for the patient's readiness to flow into a spontaneous expansion of whatever movement quality we're working on. And conversely, when working with authentic response, I'm watching carefully to see if the natural movement impulse is being allowed fulfillment or whether it is cut off by the patient's lack of flexibility in movement behavior. When this inhibition occurs, we'll often switch back to an external structure in order to work on extending the patient's range of movement possibilities.

Summary

I have discussed individual work in dance therapy and put the highest priority on a patient-therapist relationship that is built on trust. It is this focusing on the interpersonal relationship rather than the movement technique itself that is one of the most important differences between doing dance therapy and teaching dance. It requires the deliberate creation of a safe environment in which the patient can have the opportunity to discover the authenticity within himself and it involves nonverbally "giving permission" for the patient to dare to be himself. There are special conditions that indicate a need for individual sessions as there are other conditions that indicate a need for group work. The dance therapist accommodates to these special conditions and needs by working individually with the patient whenever the therapeutic relationship is best enhanced through this approach. Finally, we've explored two approaches to movement: a first approach which is most appropriate in work with psychotic patients and with patients who can benefit most from becoming more in touch with the external world. The second approach flows in the opposite direction as the patient learns to touch the source of his inner reality. Whether these approaches are used interchangeably or whether it is more therapeutic to stay exclusively with one or the other depends on the moment to moment needs of the individual. In a larger sense, both approaches are essential, as an individual's health and comfort depends greatly on achieving a balance between his inner and outer worlds.

Psychoanalytic Thought and Methodology in Dance-Movement Therapy

Elaine V. Siegel

Psychoanalysis most pointedly concerns itself with the investigation of inter- and intrapsychic conflicts as expressed both symptomatically and in the everyday life of the person under analysis. Verbalizations of both analyst and analysand are the specific tools of communication and therapeutic intervention.

The dance-movement therapist, on the other hand, expects her client to use bodily expression of both affect and intent to make his needs known. The psychoanalyst interprets verbally. The dance-movement therapist "mirrors" or interprets primarily through the use of her body and only sometimes verbally. Both analyst and dance therapist use their respective tools to give the patient a "second chance" to reconstruct his basic being and thus life itself.

The assumption is that the patient is powerless to create a satisfying existence for himself as long as inner conflicts drain his energies and prevent him from living joyfully and effectively in the present. The past has a stranglehold on his creative abilities and intellectual functioning and makes him see present occurrences only in the light of the past, with grave misinterpretations of reality as a result.

Once the conflict is brought out of its repressed state into consciousness, the patient can make a conscious choice as to life style and interpersonal relationships without the previous drain on his energy and without misinterpreting present situations. This state of affairs, this second chance or hope, can be brought about through verbal interpretation of behavior and thought in classic analysis or through mirroring and role playing, dancing out one's feelings or physically reliving the past through dance therapy.

The orthodox psychoanalyst shudders at the mere thought of actively advising the analysand, at having to offer himself as a model to be emulated. This is thought to interfere with the analysand's power to transform himself; it is seen as an undue tampering with a person's will to power and autonomy. In the treatment of neurosis in particular, utmost care is taken to prevent any intrusion of the analyst's value system into the newly emerging ego structure of the analysand. He is to be uniquely himself, with his own discoveries at his disposal without interference or intrusion.

With psychosis, more directive measures are needed by the analyst. Many of the psychotic's ego functions are severely impaired; he therefore needs more direction, and greater bridge building to reality must take place. Deviating from the classic psychoanalytic model is referred to as "using a parameter." There have emerged many analytic schools which deviate from the classic model of a minimum of three meetings per week on the couch with verbal interpretation as the major form of intervention. It is not within the scope of this paper to discuss these differences, the purpose is rather to contrast and point out the similarities of dance movement therapy with this verbal therapy.

The dance movement therapist of necessity must direct, i.e., "interpret," physically in order to effect a physical change in her client. Psychoanalytic investigations by Paul Schilder of Bellevue make a strong link between the psyche and the soma, insisting that

there is a close interrelation between the muscular sequence of the psychic attitude, that not only does the psychic attitude connect up with the muscular states, but also every sequence of tensions and relaxations provokes a specific attitude. When there is a specific motor sequence, it changes the inner situation and attitudes and even provokes a fantasy situation which fits the muscular sequence.

Quite simply, if in dance therapy we lead the client into tensing his muscles and making fists, he will usually come up with a general fantasy, such as "this reminds me of an angry person," and if he receives an interpretation that deals with his specific way of doing things, he will go on to recapture particularly angry situations in his life. This is an oversimplification, of course, and merely traces the stages of work one gets into from a mere clenched fist.

The psychoanalyst, however, is firmly convinced that "somatization" ideally should be at a minimum and confined to "trial action" within the psychic structure so that the ego can then decide what action to take in the real world. Somatization is the tendency to react to stimuli with physical rather than psychic manifestations; it is appropriate to early stages of development. The infant reacts with a howl of anger to hunger pains; the adult goes

← ID (containing drives, aggression and libido) →

Nosological Category	Age	Symptomatic Motility	Psychosexual Maturation	Drive Differentiation	Object Relations
Autism	Birth to 8 weeks	Awareness of and total response to proprioceptive stimuli. Unmotivated random movements of extremities. Focus on own internal rhythms exclusively. Inability to pick up others' rhythms.	Oral	Drive energy undifferentiated (libido and aggression both present)	Mothering object and world are unperceived.
Schizophrenia	8 weeks to 1½ years	Hyperactivity or catatonia. Body distortions with and without fantasy content. Bizarre gestures. Head rolling. Rocking. Fusion of hips and torso. Fusion of head, neck and torso. Toe walking. Tension around mouth and neck. Drooling. Biting. Dystonia. Little or no awareness of time and space. Arhythmicity of breathing and speech. Ability at height of symbiosis to imitate others' rhythms totally.	Oral incorporative	Slow separation of libido and aggression under dominance of libido (baby sucks thumb instead of biting himself). Primary narcissism.	Need gratification. (Mother is seen as feeder or breast, a part object.) Symbiosis.
Obsession Compulsion Homosexuality	1½ to 3½ years	General body tension, particularly around sphincter and buttocks. Erotization of anus. Erect, rigid posture. Tight neck and shoulders. Inability to swing pelvis. Flattened feet. Strong but constrained quality in all movements or the opposite of all of the above. Excessive sloppiness. Stubborn. Slackness of all muscles. Highly structured and constricted use of rhythms.	Anal Anal aggressive	Some frustration tolerance	Weaning and toilet training become possible because mother is beginning to be seen as a separate person.
Hysteria or	3½ to 6 years	Diffuse gestures. Directionless, but profuse motility. Restricted pelvic swing. True conversion symptoms with fantasy material. Partial anesthesias. Partial paralysis. Fusion of sensory modalities. Cramps. Headaches. Confusion of directions. Poor placement in both time and space. Vacillation between arhythmicity and total recall of rhythmic patterns of others. Shallow breathing patterns.	Phallic	Oedipal (libido is directed toward parent of opposite sex and aggression toward parent of the same sex)	Object constancy (a object can b loved despit frustrations and disappoint-ments)
Latency	7 years to			Libidinal drives temporarily abate.	
Puberty	11 years			Oedipal resolution	
Genitality	11 years to maturity		Genital	True object choice	

Depressions and phobias occur in all categories

At Birth: Undifferentiated Matrix Holding Id and Ego

ECO (containing apparatus of primary autonomy such as: intelligence, perception, thinking, motility, intentionality, object comprehension, memory)

Normal Motility	Process of Internalization	Taming of Drives	Level of Anxiety	Defenses	Superego
Waving of arms and legs. Random touching of body. Thumbsucking. Drooling. Lifting of head.	Self and object representations are merged.	Aggressive and libidinal drives are fused and often discharged inward.	Fear of total annihilation.	Introjection Projection Denial	Archaic precursors.
Rolling. Sitting. Crawling. Awareness of space. Standing. Stretching up on toes. Playing peek-a-boo. Waving. Touching of body.	Self and object are felt to be one unit.	Libido begins to tame aggression.	Fear of loss of object. In Pathology Fear of remerger with object.	Identification Displacement Turning against the self	Identification with the aggressors via identification with the weaner. First prohibition of an instinctual wish can occur.
Walking. Running. Hopping. Grabbing. (Spine is still held too rigidly for constant support. Abdomen is thrust forward. Weight on thighs, not centered above feet.)	Differentiation of self and object representation.	Neutralization begins to take place and discharge can be postponed.	Fear of castration.	Isolation Reaction formation (shame and disgust). Undoing Intellectualization Regression	Toilet training is the second prohibition of an instinctual wish via internalized reaction formation to please mother.
Body image is completed and all gross and fine motor patterns can be achieved.	Identity and sense of self emerge.	Sublimation is possible.	Fear of superego (anxiety is no longer overwhelming but becomes a signal only).	Repression	Identification with the aggressor (mother and father are right) including the ability to say "no," involving the use of aggressive drive in the service of identity.
← Flexible ego that can be the executor of conscious intent and be a buffer in the ongoing struggle between id and superego →					Establishment of cohesive psychic structure for the maintenance of internalized standards of behavior.

to the refrigerator and helps himself, without the expression of rage between stimulus and gratification.

"Trial action" refers to the thought process that delays action and rationalizes when it asks, "Shall I clobber that son of a gun who just insulted me or think of a compromise in which he will be punished but I will be the winner without hitting him physically?" In other words, the somatic expression of anger has been subdued and brought under control by the ego, which is busily searching for a way to gratify the insulted person and punish the insulter.

With such divergent views, what can the dance movement therapist take from psychoanalysis?

First and foremost, both therapies are essentially developmental in nature, expecting the client to grow out of an inefficient, fixated or infantile mode of existing into a more nearly normal one.

Theory of Maturational Evolution

Psychoanalysis as a developmental psychology offers the dance-movement therapist unprecedented diagnostic tool in its theory of maturational evolution which includes psychosexual phases, the various steps in object relationship and physical maturation.

Each of the various developmental and maturational phases carries with it a general set of movement and muscular patterns, indicating levels of object relationships which, in turn, can alert the therapist of either persuasion toward what to expect in the ongoing treatment situation. This concept is elucidated in the table at the end of this chapter.

How does this look in the dance-movement studio?

A client whose turnout would be the envy of a classical dancer but who unfortunately locks his knees so tightly that he has to walk like a robot, or someone who cannot separate hip, torso and head but uses all three body parts as one unit, obviously is not very well acquainted with his body, possibly no more so than a toddler.

The toddler is just learning that he can leave and then return to mother, that she will reappear after a lengthy shopping trip. In short, he is learning both about his body and about his love object, mother, and how far she can be trusted through the physical activity of coming and going. he is in the "separation-individuation" phase of development.

Once the therapist recognizes the "oral" level of the type of patient described above, she must prepare herself to accept the clinging, anxious behavior of such individuals and become the strong mother who literally teaches the toddler-patient, possibly of mature years, to locomote with less effort and to use his body in a fashion more appropriate to adult behavior. Such a patient would most likely be psychotic and need a "real object," as opposed to the neurotic who is expected to use his therapist as a transference object only.

In analytic language, the dance-movement therapist strengthens the ego of the psychotic patient by building the important ego function of walking while at the same time helping the patient to perceive a small wedge of reality in the form of more organically placed walking. This, in turn, is thought to allow for renewed attempts by the psychotic patient to relate to another person without distortion. Object related motor activity appears to stimulate renewed attempts at body image building and internalization of object representations.

Or, quite simply, by allowing the dance-movement therapist to help him walk more correctly, the psychotic is also saying, "Yes, there is a possiblity of loving and being loved since the person here really does not want to destroy me but is giving me something good."

"Transference" Concept

Here again the dance-movement therapist can borrow a valuable concept from psychoanalysis, that of "transference." The neurotic needs to transfer past experiences onto his therapist in order to reexamine and relive feeling states and object relationships. While the "transference neurosis" is in full swing the analysand is still aware within the healthy part of his ego that he has transferred, i.e., he knows that the analyst isn't really his mother, father, lover, etc. The analyst stays as neutral as possible and does not offer himself as a model, in order to avoid interference with the analysand's autonomy and his right to fantasize, take apart, rebuild in his own specific way. The assumption is that the neurotic has enough health left to motivate the direction of his own growth.

The psychotic, however, never having experienced a full object relationship, may yearn for or entirely spurn any real or imagined object. Whether he is autistic, symbiotic or even partially separated from his object, in order to achieve relative health he must allow himself to be led to see his therapist as a benevolent mother who can be emulated without danger to himself and who will not be destroyed by his enormous, uncontrolled aggression.

In the dance-movement studio this may mean that the psychotic patient will have to be encouraged to trace the outline of his own body and that of his therapist while listening to soothing music. He needs another chance to live through the body-image building stages of the mother-child dyad.

A neurotic patient, however, who complains of a fuzzy feeling about his body self would better be left to "free associate," in analytic language, or to improvise with possibly only a theme set by the dance-movement therapist, until he himself feels inclined to trace the outline of his heretofore fuzzy body profile.

Improvising in dance-movement therapy is closely related to free associating in psychoanalysis since both techniques are designed to tap the unconscious. While improvising in a safe situation, the neurotic may reveal an important fact or fantasy about his past relationships in the way he either tries to draw the therapist into his production or ignores, insults, provokes or implores the therapist by his conscious expressive gestures.

Depending on the stage of treatment, the dance-movement therapist may then lend himself as catalyst to a cathartic reaction or interpret via dance movement and verbalization, much like an analyst who hears, reconstructs and interprets the patient's past from verbal remembering and the observation of affect states.

Diagnosis

Recognizing "where the patient is at," moving as

accurate a diagnosis as possible of the developmental stage of the patient, is of utmost importance in both psychoanalysis and dance-movement therapy because it would be a fatal error, an interruption of autonomous functioning, if the neurotic were forced to follow a model rather than allowed to find his own egosyntonic mode of discovering body boundaries, space, affect states and relationships.

"Regression," another term borrowed from psychoanalysis, also occurs regularly in all treatment situations. Before being able to integrate and use a less self-destructive, not to say "healthier," way of existing, the patient usually has to return to the fixation point, i.e., he has to allow himself to return to that time in his personal history when the damage was done. What appears to happen is that once the infantile fixation point—the source of unwanted tensions and lack of sensitivity to body signals—has been reached, the rebuilding and reshaping of both physical and psychic attitudes becomes possible. This cannot occur until a firm transference has been established which helps the patient over the defensive anxiety engendered by the return of the repressed material.

Physically, anxiety is often expressed by extreme perspiration and heightened muscle tensions. The physical relaxation of such tensions is frequently only temporary unless it is interpreted both physically and verbally and recognized by both patient and therapist as defensive.

Defenses

Defenses and their function are another concept familiar to both psychoanalysts and dance-movement therapists. Once the patient drops his particular pattern of defending himself, recovery of memory, more correct physical placement and alleviation of symptoms follow both in psychoanalysis and in dance-movement therapy, if the therapist of either persuasion has recognized the anxiety as defensive and has lent his or her ego to that of the patient.

However, both psychoanalysts and dance-movement therapists must remember that defenses also serve an adaptive function. The patient breathes in a shallow fashion or holds his back rigidly, because this once helped him through a traumatic situation which he has been unable to resolve.

Defenses must be dealt with gently in both therapies until the patient is ready to give them up in favor of a new, less distorted, natural way. Saying "do it my way" and showing how to do it may give structure to the psychotic ego but will be absorbed only by the superego of the neurotic and thus become another rule rather than stimulate organic growth.

Countertransference

Another common occurrence in both therapies is the development of countertransference. Roughly, this means those feelings within the therapist toward the patient which are not caused by the immediate relationship within the treatment situation but are echoes from the therapist's own past, triggered by something similar in the here and now with the patient.

One frequently hears the assumption that a relaxation technique, a movement pattern, an exercise are offered because they feel good to the therapist, who assumes they will therefore also feel good to the patient. This, of course, is the most obvious countertransference, almost a fusion of identities, which should be examined carefully.

Compelling the loosening of the rigid spine and tight sphincter of an anal-compulsive patient, for instance, because the therapist herself feels better in a more relaxed body position, may engender anxiety in the patient, which is then frequently mistaken for catharsis because of extreme muscle tremors and premature cracking of the characterologically caused posture.

The other extreme of the effects of unrecognized countertransference is visible in those patients who stay in therapy for years without any significant change. Boredom and exasperation within the therapist stop her from devising new dance situations or trying to bring the defenses into focus.

The need to be the perfect mother or the need to encourage body contact for the therapist's own reassurance are other obvious countertransference manifestations.

An example of a positive use of countertransference would be awareness within the therapist that a supposedly autistic child is "likable," i.e., emanates an unspoken need to be liked, which would make the little patient far more treatable than if he were totally closed off. An unspoken realization within the therapist that a violent patient is merely frightened would also be a useful countertransference tool, indicating that the therapist had understood her own aggression pretty thoroughly.

Even in perusing only these basic terms and concepts of psychoanalysis it becomes apparent that psychoanalytic theory and methodology are applicable in almost all phases of dance-movement therapy and offer the therapist both an effective diagnostic tool and a methodology which will make her a more effective and far-reaching catalyst for her clients' conflicts.

The Developmental Outline Chart attempts to elucidate and tie together those developmental concepts most useful to the dance-movement therapist (pp. 28 and 29).

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Techniques for Research and Observation Part III

Elissa Queyquep White

Effort-Shape: Its Importance to Dance Therapy and Movement Research

Movement in itself is a language in which man's highest and most fundamental aspirations are expressed. We have forgotten not only how to speak this language but also how to listen to it. Movement has a quality, and this is not its utilitarian or visible aspect, but its feel. (17:65)

These statements characterize the effort-shape system of movement analysis and capture the thinking of its creator—Rudolph Laban.[1]

There are two important things to keep in mind about effort—it is universal, as it is applicable to all movement, and it requires a new way of thinking.

It is perhaps not too bold to introduce. . .the idea of thinking in terms of movement as contrasted with thinking in words. Movement-thinking could be considered as a gathering of impressions of happenings in one's own mind, for which nomenclature is lacking. This thinking does not, as thinking in words does, serve orientation in the external

[1] Laban was familiar with architecture, painting, dance/movement and psychology. He traveled freely through artistic and scientific circles, thus giving him the freedom and knowledge to conceptualize theories and notation systems about movement.

world, but rather it perfects man's orientation in his inner world in which impulses continually surge and seek an outlet in doing, acting, and dancing. (15:15)

This movement-thinking is what effort is about. It is a descriptive method of analyzing and recording (notating) the observable process of movement. It describes not what is done but how the movement is done in terms of force, space and time. Effort-shape looks at the components of movement in terms of how kinetic energy (effort) and spatial structure (shape) are utilized by the body.

Effort System[2]

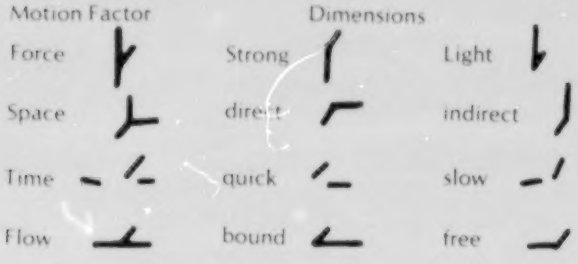
Effort is a system which describes the dynamics of movement in terms of four motion factors: space, force, time and flow. For each factor there are two dimensions: space (direct-indirect), force (strong-light), time (quick-slow) and flow (bound-free). To Laban, these motion factors are the ways in which inner impulses and energies are manifested in movement, whether conscious or unconscious.

Laban conceived the following effort graph from which effort symbols are derived:

He postulated that certain efforts can be described as struggling or fighting against, and others as yielding or indulging. The fighting efforts—direct, quick, strong, bound flow—give the image of flight or struggle against. *Direct* is channeling through or piercing space; *quick* is fighting against time; *strong* is compressing energy; and *bound flow* movement can be stopped at any moment through fighting one's own energies.

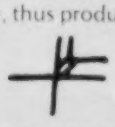
The indulging efforts—indirect, slow, light and free flow—allow movement to spread throughout. *Indirect* is meandering and spread throughout space; *slow* is melting and indulging in time; *light* is floating into and overcoming gravity; and *free* flow is ongoing and continuous.

The effort graph breaks down into the four motion factors as follows:



Shape System

Lamb's (18) concepts of shape as they correlate with effort enabled him to use the effort graph by adding another diagonal line, thus producing the shape graph:

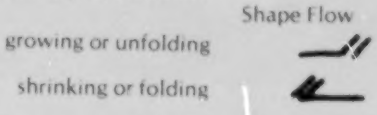


[2] For a detailed explanation of effort-shape and supplementary concepts as well as notations of phrases, see Dell (8).

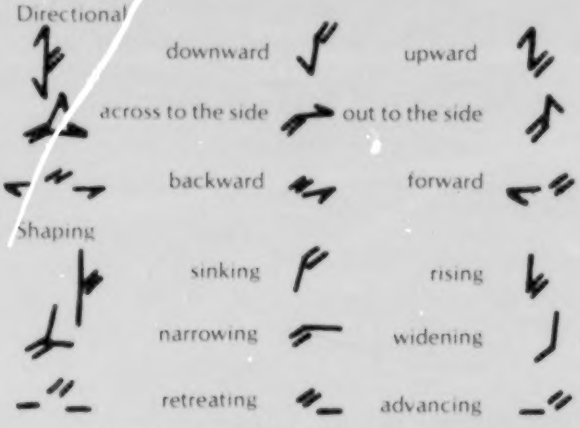
Shape is a system which describes how and where movement goes through space in terms of shape flow, directional movement (linear or arc) and shaping movement (three-dimensional use of space). The difference between these three movements is in the "character" of traversing through space from vague in-out pulsations which do not have clear projection (shape flow), to movement which is distinctly goal-oriented (directional movement), to movement which not only projects through space but creates a three-dimensional form of the body and space it penetrates (shaping movement).

Shape flow is movement that goes toward or away from the body, such as folding or unfolding of the limbs and shrinking or growing of the body. It is oriented more towards the body than towards the space surrounding the body. Directional movement is movement through space that is linear, arc-like or spoke-like. Shaping movement is movement clearly projected into and moving through space three-dimensionally in a "sculpting" manner. Generally, shaping terms "suggest the emphasis on the body's involvement in forming or adapting to space, while directional terms stress the concern with going in specific directions" (8:57).[3]

In notating, the shape flow aspects of movement are usually recorded as:



Note their similarity to effort flow symbols. Directional and shaping symbols are very similar; directional movements are distinguished by a "hook." The terminology is designed to capture the distinctions between the two types of movement:



It is difficult to write briefly about the interpretive aspects of effort-shape qualities because they are based on experience as well as on ongoing research studies. Also, movement interpretations are guided by an overall movement analysis, not just by single elements. However, in a broad sense, effort deals with a person's coping abilities and shape with relationship to his environment.

[3] See Laban (16) on the study of spatial harmonies and relationships. Also see Dell (9).

Additional Movement Factors

In addition to the effort and shape qualities mentioned above, other elements of movement are usually observed and recorded. They are:

Body Part—Part or parts of the body which initiate a movement sequence.

Gesture-Posture—A movement that is gestural (limited to one segment of the body) or postural (spreading throughout the body even though it may begin in one part of the body).

Body Attitude—The constant carriage or stance of the individual in terms of spatial stress in a plane, areas of restriction, use of the torso, etc. For example, a person may be sitting erect, emphasizing the upward-downward stress of the vertical plane; another person sitting erect may be stressing the side-to-side dimension of the vertical plane.

Kinesphere—The range or degree of space used in relation to the body.

Combinations of Effort Factors

The preceding has been a listing of the elements used in effort-shape. What must be understood is that no one moves with only one element. A person always has one, two or three of the effort (motion) factors as well as shape qualities. It is the way in which people use the combinations which makes for the uniqueness of each person. Given that each person has an individual style, there are infinite ways of moving.

Laban speaks of motion factors (or efforts) as reflecting inner drives or impulses from which movement originates. In a given movement, one or more of the motion factors may be used. As a result, there are infinite combinations and varieties of movement. For example, a person's movement may exhibit the primary motion factors of flow and force; however, within these factors he will also exhibit free or bound flow and strong or light force, as well as concomitant spatial patterns.

In *The Mastery of Movement* (15), Laban states what he considers to be the meaning of the motion factors: Space gives information about *where*; force gives information about *what*; time gives information about *when*; and flow gives information about *how*. From these four factors, Laban has evolved a theory about inner attitudes (or incomplete effort) and drives. A combination of any two of the motion factors is considered an inner attitude or incomplete effort. There are six possible combinations, each having two dimensions.

Space + Time (where and when) = Awake
Flow + Force (how and what) = Dreamlike
Space + Flow (where and how) = Remote
Force + Time (what and when) = Near
Space + Force (where and what) = Stable
Time + Flow (when and how) = Mobile

A combination of any three motion factors is considered a drive. There are four combinations.

Space, Force and Time (where, what, when) = Action
Flow, Space and Time (how, where, when) = Vision
Flow, Force and Space (how, what, where) = Spell
Flow, Force and Time (how, what, when) = Passion

The action drive constitutes "the most highly crystallized exertions described in the system" (8:37). In the spell drive, "the inner attitude towards time rests and the movements radiate a quality of fascination"; in the passion drive, the space effort is "dormant and bodily actions are particularly expressive of emotion and feeling" (15:85).

This is, in effect, a theory of emotions, which is further enriched and modified by the variations in spatial patterns that the movements form.[4]

Although Laban's description of the effort system and the meanings he attributes to the motion factors are quite explicit, the observation of movement in these terms requires that the observer have some command over and knowledge of the meaning and experience of these factors in order to make the connection between movement-thinking and word-thinking.[5]

Applicability and Research Using Effort-Shape

Effort-shape principles are applied not only to the observation of dance/movement but to the implementation of it. The application of these principles enables the dance therapist, choreographer and teacher to know how body parts move in relation to one another, where the flow of movement is stopped or restricted in the body, and which effort and/or shape qualities can be used to enhance, explore or broaden one's movement repertoire, allowing for new experiences, sensations, insights and potential for change.

Effort-shape movement studies look at style, whether it be style of an individual, group or dance composition. Style in the individual is sometimes referred to as temperament, personal characteristics or movement repertoire. This area has been explored in studies dealing with child development, style of a particular choreographer, movement repertoires of individual dance therapists and how this affects a group, an individual dancer's style, and changes in movement patterns of hospitalized psychiatric patients. Group style has been explored in anthropology, small group behavior, and in a broader sense, in particular dance compositions.

Although effort-shape is still in its infancy in this country, in England several people have applied effort to their disciplines for many years, including as an educational approach to dance in primary schools. Warren Lamb (19), who added shape to effort, has used the system to assess aptitude in management. North (21) has used effort to assess children's personalities and, based on these assessments, has used movement therapeutically with the

[4] For an extensive use of this aspect of Laban's theories, see North (21).

[5] My own bias is that people who use effort-shape should be trained in the principles of both movement and observation. However, this does not negate the notion that observers can be trained to observe certain parameters depending upon the type of study undertaken. My feeling, though, is that learning effort-shape through movement helps to bridge the gap between movement-thinking and word-thinking and enables one to have a deeper understanding of movement. This is obviously important for people who wish to use effort-shape to enhance their work as dance therapists.

children. In her book, she describes the application of these assessments in certain areas of industry.

Irmgard Bartenieff, who studied with Laban and Lamb, has been the most responsible for introducing effort-shape to a broad spectrum of people in this country. Bartenieff had the foresight to train two people, Martha Davis and Forrestine Paulay, who instituted a training program at the Dance Notation Bureau, Center for Movement Research and Analysis, in New York City. In the studies which follow, each investigator had the good fortune to have trained and worked with her. Bartenieff's contributions have played a large part in the understanding and crystallization of their thinking and work.

Observing, recording and analyzing movement in effort-shape terms is dependent upon the type of study that is done. In some cases, modification of the system has been made according to the researcher's needs and the work under study.

In the past, effort-shape has been used mainly for teaching dance, but is recently being applied to choreography and dance criticism.[6]

In dance research, Davis and Schmais conducted a pilot study in which they abstracted the theme and variations of an important dance composition using five effort-shape parameters (7). This procedure could become an important asset. One could begin to compare choreographers' works and styles with one's own compositions. More important is that the reconstruction of compositions would not have to rely on steps or memory alone. In most cases, it is the choreographer's style which gives life to his works. Thus, a study of effort-shape could conceivably aid the reproducibility of a work as well as our appreciation and understanding of it.

In social sciences, the application of effort-shape has spread simultaneously in several fields—anthropology and psychology. In anthropology, Bartenieff and Forrestine Paulay collaborated with Alan Lomax to develop a "choreometrics" coding sheet based largely on effort-shape parameters. They used films of dance and work situations of various cultures. Cultural movement style, rather than individual style, was the main focus. A notable finding was that "... the number of movement components available in a repertoire and constantly in use is a good index of the relative complexity of a culture in an overall sense" (20:240).[7] Research on the movement styles of various cultures should have a profound effect upon the understanding and teaching of ethnic dance.

In psychology, movement research has ranged from studies of psychiatric patients in group and individual situations to studies of child development. For the past 10 years, Judith Kestenberg, a psychoanalyst, has trained notators to conduct research in child development (12, 13, 14). She has adapted effort-shape analysis for correlating movement patterns with stages of psychosexual development. For example, the observation and notation of movement parameters of tension flow and shape flow are notated in such a way as to enable the researchers to see patterns of flow rhythms. Her longitudinal studies show that tension and shape flow curves in early infancy and childhood are precursors of effort-shape patterns observed in later years. Kestenberg, together with her group, the Sands Point Movement Study Group, will undoubtedly make significant contributions to psychoanalysis.[8]

In 1965 Bartenieff and Davis wrote a monograph which describes preliminary observations of hospitalized psychiatric adults(3). As an outgrowth of this work, interest in the movement characteristics of psychiatric patients took two forms: the systematic study of patients during individual psychotherapy sessions and the application of effort-shape to dance therapy. The latter led to some theoretical formulations concerning dance therapy (22) and concepts regarding the training of dance therapists (23).

Davis, a psychologist, has conducted the most systematic study of hospitalized psychiatric patients(6). Patients were observed through one-way mirrors, without sound, in individual psychotherapy sessions upon their arrival in the hospital and three to four weeks later. They were rated by Davis and at least one other observer on the Davis Movement Diagnostic Scale (70 items). Eight movement factors were abstracted from the scale, and many of the findings suggest that further movement studies such as this will contribute significantly to the diagnosis, prognosis and treatment plans for psychiatric patients.

Studies in small group behavior were conducted by Bartenieff and Davis (4) and Davis (5). The first, a study of group psychotherapy sessions, shows how movement can sometimes be a clearer indicator of emotional involvement and change in a group than words. The second study, a comparison of methods of perceiving small group behavior, illustrates how effort-shape reveals recurring patterns of interaction.

Dance Therapy and Effort-Shape

The application of effort-shape to dance therapy seems natural for several reasons. First, although both disciplines require different skills, they have much in common—movement and the observation of movement. When studying to become a dance therapist, a student must learn such skills as how to communicate with patients, how to keep a group together, how to pick up and develop movement and, mainly, how to be a therapist in movement interaction. Learning effort-shape also has its definite skills—how to observe, what principles and parameters are involved, how to notate and analyze one's observations, and becoming familiar with all ways of moving as prescribed within the system. For the dance therapist, observing a patient's movement behavior in dance therapy sessions is crucial because it supplies the cues with which the therapist must work. For the effort-shape analyst this movement behavior is observed, notated, analyzed and then applied to whatever subject is under scrutiny.

[6] For dance criticism, see Siegel (24).

[7] See also Bartenieff (2) for illustrations of the differences between two cultures.

[8] See also Kalish (10) for a study of developmental patterns in autistic children and White (25) for a pilot study of movement characteristics of infants 4 weeks to 32 weeks old.

Secondly, a theory of dance therapy needs to be developed based on movement principles with a language of its own. Since effort-shape deals with the process of movement and employs consistent and scientific principles, it could be used to develop such a theory, much as mathematics has been used to develop theories about physical reality. Although the need for such a theory is often espoused, many dance therapists relate their work to psychological and/or psychoanalytic theories.[9]

As dance therapists we presumably work with certain beliefs about movement. Movement says something about an individual—his state or mood, his flexibility or rigidity—and that in some way movement interaction can enable a person to change or, at the least, can permit him to have a new experience or sensation. We know this intellectually and experientially and understand that movement is not only functional but also communicative and expressive. Given these convictions it behooves us to develop a theory of dance therapy based on movement principles.

In line with developing movement theories, there is a great need for conducting research. With a system such as effort-shape, research in dance therapy could be begun in several areas: the process of dance therapy itself, movement behavioral changes in patients over a number of sessions, types of movement patterns or repertoires best suited to treating specific patients, etc. A more important area, of course, is the need to validate what we do, first, to dance therapy as a discipline and secondly, to mental health, a field in which dance therapists are involved.

Although there are many directions research in dance therapy could go,[10] the argument outlined above for developing dance therapy theories based on movement principles also applies here. Such pilot research has been undertaken. For example, Kalish (10) has used her research findings on autistic children to gain a better understanding of how to work with them. A study such as Davis' on movement characteristics of hospitalized psychiatric patients (6) is extremely valuable because if a patient manifested all the movement characteristics in one of Davis' factors, the therapist would know immediately what is occurring.

At Hunter College in New York, Claire Schmais and I have found effort-shape to be a valuable tool for training dance therapists. One of our basic beliefs is that everyone training to be a dance therapist should know himself in movement terms, his consistent patterns, potential for change and the type of interaction his movement repertoire fosters. Effort-shape provides students with a means to analyze movement behavior of individual patients and of a group. It also helps instructors to be specific in guiding students during both classwork and their subsequent work with patients.

The last important area in which effort-shape can be tremendously helpful is in clinical work with patients. It enables the dance therapist to observe what is occurring strictly on the movement level. Since effort-shape is based on systematic principles, it increases one's understanding of logical sequences and progressions in movement and helps the therapist understand her observations and the direction in which she can take a patient based on his movement behavior.

Because effort-shape has a language to record movement behavior, it gives some credence to the therapist's interpretations of patient behavior. It also helps the therapist to communicate not only with colleagues but with other persons professionally involved with patients.

[9] I do think it important, however, for dance therapists to know and understand these theories.

[10] For example, see Kendon (11) and Adler (1).

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Working with an Autistic Child

Beth Kalish

When we, as therapists, first meet an autistic child, we observe his body movements, his use or nonuse of space and his reactions to us as new persons in his environment. Does he shrink from us when approached? Does he allow himself to be touched? Is his posture rigid or in constant motion? These are important factors that sensitive therapists note in their initial evaluation and continue to observe during the child's treatment.

On what level do we make use of this knowledge? Many of us are unaware of the vast information that can be gained from analyzing a child's movement cues. Sometimes they are the only signs of his life force.

We as adults have our own particular bias about what a series of actions may mean to a child. Because our interpretations are often subjective, we can easily fall into the trap of imposing our movement value system on the child. In his book *The Silent Language*, Hall discusses how we often assume that our own concepts of time, space and patterns of movement are the concepts of others (4).

Pilot Study Results

Several years ago my colleagues and I conducted a two-year pilot study at the Center for Autistic Children to find out how adults see movements in autistic children. We designed a questionnaire, based on normal movement

qualities, using simple action words such as running, skipping and jumping. We chose words that had universal meanings in our culture. Our observers were professionals, such as psychiatric residents, nurses-in-training, psychologists and psychoanalytic students. Very quickly it became apparent that most of them were poor observers of movement, even though they had stated that they were sensitive to nonverbal communication manifested in disturbed children. Their observations repeatedly substantiated our thesis that most of us see, respond to and evaluate movement subjectively.

This pilot study raised the question: If we cannot even agree on the differences between certain kinds of movements when we are observing, how can we, as therapists, use our movements effectively in working with these preverbal, autistic children? We certainly need to know more than what we can learn through our own life experience. The study of movement parameters with trained observers is a new area of research (1). Only a few people are intensely involved in it but the interest is growing.

Body Movement Scale for Atypical Children

At our Center, we are attempting to adapt effort-shape analysis (7) to our work with autistic and other atypical children. Using the terminology of effort-shape as a base, we have designed and are now validating a Body Movement Scale for Atypical Children (5). This scale allows us to evaluate a child's developmental stage and, when used over a period of time, can measure changes in the child's movement behavior. It has particular relevance for diagnosis and developmental evaluation of children who do not or cannot communicate verbally.

It is hypothesized that the scale will prove sensitive enough to reveal subtle signs of disturbance in normal children under five. Should this be the case, the scale could be valuable for predicting incipient problem behavior in preschool children, where movement is still used as a primary mode of communication. In a small pilot study undertaken by the author, the scale was used by trained raters to observe and score 20 children in a normal preschool class. Although 12 of the children were found to be functioning at appropriate age levels, the rest of the children were found to be exhibiting immature and/or disturbed movement behavior. This study and subsequent ones have led us to believe that this scale can be used with a broader population than the autistic one for which it was originally designed.

Active/Passive Behavior

Our observations over the last 10 years have led us to believe that severely autistic children fall into two extreme but basic types of movement behavior—active and passive. As an autistic child becomes less disturbed, these extremes tend to become more similar to a normal range of movement, yet the child retains some lesser elements of the earlier, more extreme form of moving, e.g., slightly hypoactive (passive) or slightly hyperactive (active). These slight tendencies are present in all of us. The difference is in the quality and quantity of movement behavior in any given person.

Our findings have led us to discard the term *bizarre movements* in relation to children. We submit that there is no such thing as a wrong movement. As researchers and therapists we must examine what a child's movements might tell us. How does it feel to do them as the child does? Can we make use of them to communicate, to meet the child where he is functioning, using his level of intensity and his choice of rhythm and speed? We need to experience these qualities in our own bodies before we can empathize with the feelings they create in others.

Movement Behavior of Therapist

For a number of years I have been concerned about the movement messages that autistic children receive from their therapists and others who work with them. How aware are these adults of their own movement behaviors and what are they projecting to these preverbal children? This is a critical issue, particularly for movement therapists.

Kestenberg (6) and Schmais and White (8) have dealt with the importance of the therapist having his own movement analysis in order to evaluate thoroughly the interaction process that occurs in therapy. I would like to go a step further in stating that when one participates in a therapeutic session, this knowledge must become absorbed into the mind and body of the therapist to allow the process of spontaneous interaction through movement, sounds, touch and sharing of space to blend together. This blending, or total gestalt, of the created therapeutic environment can allow for variety and change to take place which, it is hoped, will breach the autistic barrier. Of course, it is the most difficult area to describe because it relates to the magic of it all. It is truly the art of therapy and possesses an aura of its own.

In the temporal sequence of the development of action, the acting with the other person is fundamental. In this acting with one another, an acting subject does not face an object of the action, but action and counter-action go back and forth, and it is solely a matter of viewpoint whether we regard the one or the other as subject or object of the doing. (2:71)

In his important work, *An Essay on Man*, Cassirer (3) postulates that only after acting with one another can man turn back upon himself. But what of the autistic child who has no sense of "I" or center of self or for that matter, any recognition of a difference between self and non-self? What of this child who functions like a newborn in a big body? Are there any clues for building bridges for such a child? To those who are sensitively attuned, there are continuous clues. On occasion, there can be even a single session in which the therapist actually sees dramatic changes occur within a few minutes.

The following is an illustration of such a session. Sarah entered the room crying, twisting her right ankle as she walked and hitting her side with her left fist. Her movements were extreme boundness in the torso, with little variation. Her whole body wanted "out." Her gestures reflected this desire to get out of the room. Her use of effort reflected extremes of direct/indirect, strong/light, and slow. Note that two elements are alternating extremes. Shape flow dimension was in (toward her own body); kinesphere was close (her own space, around the body). She limited herself in the room to the corner nearest the exit door—only moving out a few feet and back again. Her movement phrases were short and repetitious, unlike her phrases on "better" days.

I attempted to meet her level of intensity by making my movements bound. I started with the ambivalence her body demonstrated by introducing actions that fluctuated between direct/indirect and strong/light. Sometimes I imitated and reflected. Other times I introduced new movements but with the same qualities since it is the qualities that seem to make the difference in communication.

Since the structures in autistic children cannot be changed, we must help the child begin to build new ones. Thus, instead of trying to enter Sarah's space, I created another spatial design near enough to hers that it would almost enter but not quite. I faced her only at a distance. I backed toward her and then moved away. She began to come after me as long as my back was toward her. As she came near the second time, I felt her touch me lightly and I reached around in back and touched her—lightly. Her mood changed to a playful response. The twisting and hitting became less intense and more mechanical. Sarah made a few feeble attempts to repeat the earlier movements but they were not convincing to either of us; the lure of the touch game was far greater.

Sarah was able to relax her entire body. As her tension decreased, her movements became more consistently direct, slow and light; the ambivalence demonstrated in the earlier movements disappeared. The session ended with cuddling and rocking movements together on the floor. We were both sharing the same space. Sarah could now focus on watching my mouth movements. She made several attempts to push out low sounds imitative of my movements and sounds as she sat quietly on my lap. Only 20 minutes had passed.

Movement had penetrated Sarah's defenses and she had allowed someone to become an object in her internal environment. Hopefully, a relationship had begun.

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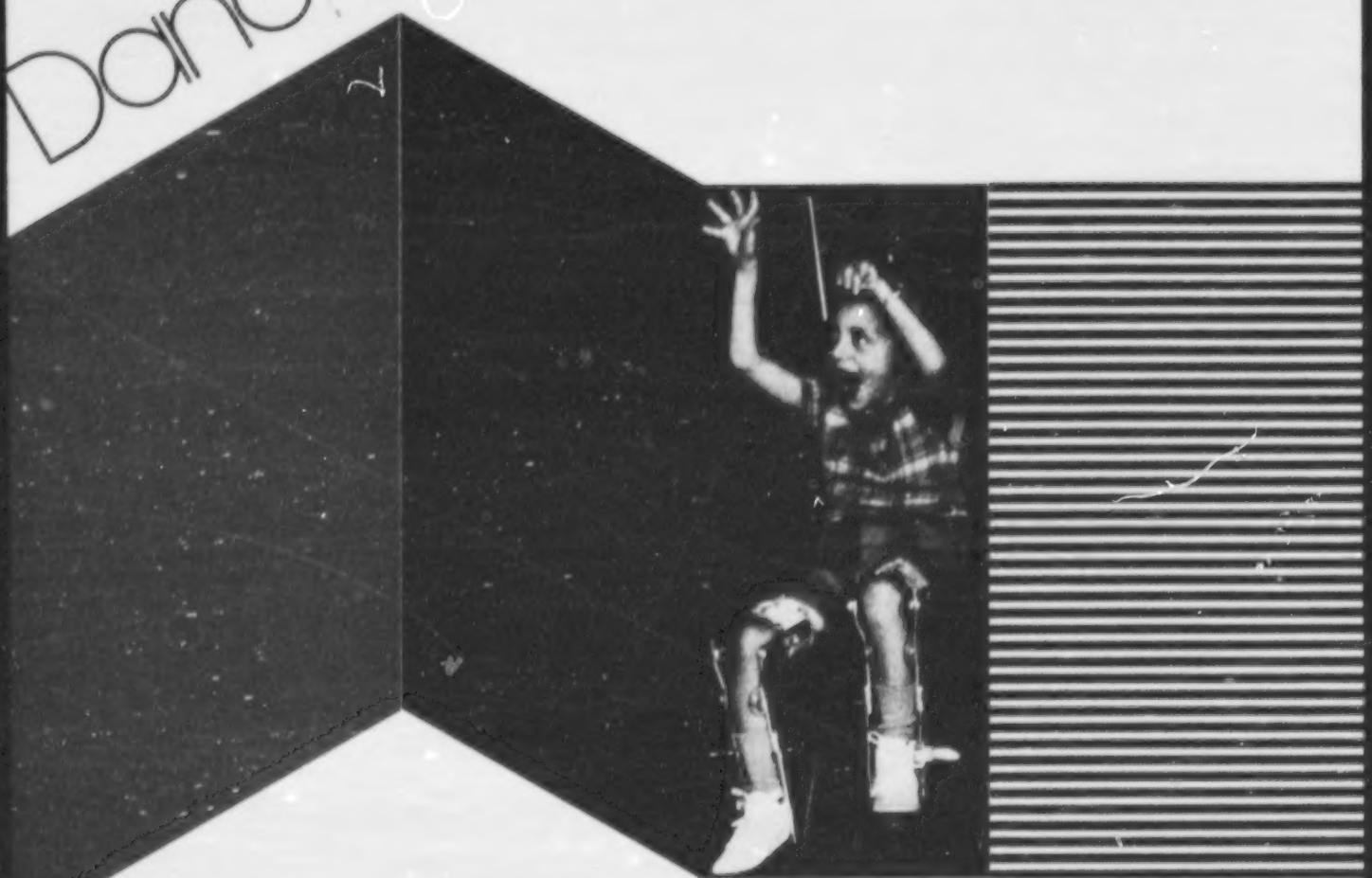
Dance for Special Groups



Part IV

Movement Therapy with Minimal Brain Dysfunction Children

Marcia B. Leventhal

Movement therapy with children who have minimal brain dysfunction (MBD) (15:3) has the potential to fulfill a variety of educational and therapeutic goals. Experiences developed in movement therapy may influence a child's capacity to learn by dealing 1) directly with the construct of the learning disorder or 2) with a particular behavioral dysfunction. Movement is a particularly useful tool in helping to relieve a child's anxiety, helping to focus the hyperactive child and helping the MBD child to establish a more positive self-concept.

In its ideal form, movement therapy develops as part of a child-centered, multidisciplinary approach. Movement is at the core of our total development and has a profound influence on learning of speech and socially acceptable behavior and on development of learning skills. Presenting movement therapy in isolation would defeat its purpose since movement therapy is concerned with the whole child functioning on a healthy emotional, social, physical and intellectual level. Movement is at the core of synthesizing and integrating inner and outer stimuli and should be an integral part of a program developed by educators, psychologists, social workers, speech therapists and physicians.

As a technique of therapy, movement with the MBD child is derived from several constructs and theories. Though its long-range goals do include the influence of dance and dance's subsequent development of imagination and use of fantasy material, in its initial application movement therapy for the MBD child develops from a base both broader and more specific than that of dance alone. At first movement therapy is a concrete, highly structured approach, integrating and developing the constructs and theories inherent in the principles of body image and schema, sensorimotor development, learning readiness and ego psychology.

This article will define the symptoms manifested by the MBD child and relate them to the influencing construct which helps structure the movement therapy. It will become apparent how much the constructs overlap and that often by alleviating, for example, a perceptual-motor symptom, one finds that a cognitive or behavioral problem also disappears.

Symptions of MBD Children

The MBD child's symptoms may range from a behavioral disorder to a learning disability, depending upon the extent of his neurological impairment. Though the symptoms vary, and some seem to vanish as the child matures, the most basic single characteristic seems to be an inability to organize internal and external stimuli effectively. The MBD child is unable to assimilate, integrate and perceive experiences which would free him to proceed logically to the next developmental step. If, as Rudolf Arnheim theorized, we only perceive that which we have experienced, and experience is gained through basic sensory stimulation (1:364), then we begin to realize the importance of sound, basic sensorimotor learnings.

The sensorimotor apparatus is the foundation for later more complex perceptual and cognitive development. Sensory impairments become manifest in a variety of ways. Often a child seems restless with an inability to focus. He may have a short attention span, making the acquisition of learning skills quite difficult. He is often anxious with low feelings of self-esteem, which affects his inability to focus even more profoundly. Often he exhibits antisocial, negative behavior. In the area of learning, the MBD child often has difficulty with arithmetic, has a tendency to reversals in reading and spelling, and has slow, messy writing. In essence most of the disorders point to a difficulty in abstraction and conceptualization (i.e., the process of internal thought) (13:19).

Frequently there are symptoms in various perceptual-motor disorders which often affect learning skills. In describing the process which links motoric learnings and cognitive skills, Kephart states that one aspect of the difficulty is related to the MBD child's inability to internalize motor generalizations.

A motor generalization can be seen as the child is able to accomplish a complex, coordinated sequence of movement patterns which accomplish a purpose. The important function of the motor generalization is to allow the child sufficient freedom of response so that his attention is no longer required by the movement itself. He is now free to attend to the purpose of the movement, and to gain information about his environment. (8:85)

Kephart feels that too many children with learning disabilities have learned movement patterns as skills "and consequently their responses are stereotyped, rigid, and may or may not be purposeful. They haven't learned to generalize these patterns and adapt them to a wide variety of situations" (8:85).

Movement Therapy for MBD Children

In movement therapy, emphasis is given to experiencing the component functional and dynamic elements of a skill rather than to the teaching of the skill. In this way the child in treatment is able to develop the range needed for organizing, interpreting and manipulating the object world meaningfully and adequately—the very functions of motor generalizations. It is Kephart's feeling that motor generalizations provide us with a fundamental perceptual-cognitive structure, which in turn allow perception and integration to take place. The primary thrust of movement therapy is towards such a goal.

By helping the MBD child to reexperience, rebuild and often experience for the first time those elements upon which a healthy body image and body schema are built, he can make dramatic growth and change in the areas of control, visual-motor coordination, gross motor development and self-concept. Movement therapy makes its most valuable impact in its ability to integrate stimuli. Component elements are "teased" out, experienced and defined, and gradually reblended until internalization takes place, and ultimately the reintegration of the basic sensorimotor modalities occurs.

In the various separate research of Barsch, Cratty, Frostig and Kephart (2, 3, 6, 8), the importance of movement as it relates to total development is often stressed, with the further implication that movement may influence a child's intelligence and ability to learn. There are several concepts which are repeatedly cited as the most crucial to the eventual ability to master learning or readiness skills. Gravity and posture, differentiation of self, and definition of space and time seem to influence a child's ability to focus, to abstract and generalize, and to internalize laterality and other crucial perceptual concepts. Kephart has indicated that in early childhood, motor activities play a major role in intellectual development, and that so-called higher forms of behavior develop out of and have their roots in motor learning. And probably most crucial to the awareness of the scope of movement's influence, and to the importance of a sound, concrete, highly structured, developmentally integrated program, is that "the higher thought processes can be no better than the basic motor abilities upon which they are based" (8:35).

The child's sensori-perceptual-motor development is a delicate structure: one impediment can affect him on a highly sophisticated level, and likewise, the removal or amelioration of a block can cause an entire organizational scheme to fall into place.

It is apparent that regardless of one's personal style of movement expression he must be flexible if he is to meet the challenges of a constantly changing environment. The MBD are invariably inflexible in their range of movement. Therefore, range of choice and ability to think and abstract is one of the fundamental considerations upon which

movement therapy develops and builds. Whether MBD children are seen as hyperactive or hypoactive and listless, they have not developed an internal sense of time, space or energy flow. Many seem not to have developed a sense of their center of gravity, or even more basic, a sense of their physical self. It is here that movement therapy begins to make its contribution. By dealing directly with the perceptual-motor or sensorimotor area of difficulty, positive changes become apparent in behavior and in learning. Movement therapy builds both sequentially and developmentally from sensory awareness, to body parts awareness, to sense of self, to movement dynamics, to locomotor movement, to expressive movement. Each is a complete structure within itself, and necessarily influences the area which follows it.

In order to understand how the program develops sequentially, a discussion of the theoretical concepts follows. How they influence and are integrated in movement therapy will be included.

Body Image

Body image is one of the most fundamental of all growth concepts in human development. A generally accepted definition is that the body image is a three dimensional image formed from the tactile, visual and kinesthetic receptors, resulting from both internal and external stimuli. It is not identical with self-concept but seems to reflect the self. It has been hypothesized that the stronger and more accurate the body image, the healthier the self-concept (11:4). It is not static, but in continual growth or decline. Concerning our particular focus, one's motor control plays a special role in the creation of, or even disintegration of, the image. Research has indicated that the child's mental image of his body, how it appears or feels to him, becomes the foundation or integrating factor of the self and the ego. When there is a faulty or not completed image, it has been found that perception and subsequent understanding is distorted (14:45). This is one of the determining factors in causing classroom readiness skills (such as concept formation, language arts, impulse control, auditory discrimination, fine motor control, and social awareness) either to develop or become blocked.

Through the sensations created by actions of the muscles a great awareness of one's moving parts develops. In order to move, however, it is necessary to have an image of the body. Since the body image is apparently built through sensory stimuli coming through the brain and then reinforced by meaningful movement, the development and awareness of the tactile, visual and kinesthetic receptors are necessary for the building of an adequate body image. Hence the initial or most basic movement experiences are sensory in nature, related directly to the defining of body parts and boundaries. Herein lies the beginnings of self-awareness and ultimately personal integration.

The body image is a cue against which all perceptions are measured. Fischer and Cleveland have determined that a relatively intact body image is an anchor point or foundation necessary for the performance of certain judgments and skills (5:9). For example, one does not perceive space (and subsequently one's environment), unless he perceives the space of his body. Directions in space such as up and down, forward and backward, and side to side (or laterality) will not develop and will hinder the development of crucial learning concepts. Movement therapy enables a child to have felt experiences, sensed physically, on the kinesthetic level. Gradually, as experience becomes internalized, a label or symbol is attached, and finally a concept is able to be abstracted and generalized.

We have a clearer picture of our body when it is in motion than when it is at rest (7:84). It is clear then that the early movement therapy experiences should be based upon tactile stimulation of body parts and boundaries, articulation of body parts, and visual-kinesthetic awareness development. These are developmentally some of the early sensorimotor awareness activities from which the child becomes able to define internally the parts of his body and its boundaries. The next step sequentially is the experiencing of the torso from the lower body; then the child is ready to sense gravity, weight and energy flow.

Energy Flow

Flow, or flow of energy, is a concept one finds at the core of the various body therapies. It is encountered in bio-energetics, in yoga, in the Alexander Technique and even in acupuncture. It is sometimes referred to as the life force, and the Soviets in their psychic research and development of Kirlian photography (a system of recording energy vibrations or emanations from plant and human life) have been quite concerned with its properties. They feel that it might be the missing link involving ESP, natural healing and acupuncture (12:211). It has been described as the foundation of the "inner self," with the rhythmic changes in breathing and the constant responses of the body to both inner and outer stimuli providing a constant stream of urges to move—the quality of the urges being flow (4:15).

In effort-shape movement description, flow has been described as a kind of substrate in movement. Out of it "crystallize" changes in the qualities of force, time and space. It is a description of the alive, energized state in which we find the human body. The two opposite qualities of the flow factor are free-flow and bound-flow (4:15).

Though to describe flow is to indicate a kind of ethereal concept, an awareness of this property greatly heightens the movement therapist's sensitivity to a child's needs and physical motor development. In its properties lies the potential for movement analysis and description.

Kestenberg, collaborating with the Sands Point Movement Study Group on child development research, has developed a comprehensive movement profile based upon her research in flow. She considers flow as the flow of tension and sees it as an expression of our basically endowed drives, present at birth. Kestenberg feels that tension flow is an expression of the contractions of the agonistic and antagonistic muscles. Relationships between the muscle groups can be either complementary (free-flow) or opposing (bound-flow). She further ascertains that it is not the presence of tension but the quality of tension which makes movement flow freely or with boundness

(4:14). Kestenberg has isolated "qualities" or "attributes" of tension flow. An awareness of these attributes helps the movement therapist to help a child develop a range of energy flow. She feels that the attributes are the precursors of the force, time and space elements of energy. The attributes are levels of tension (degree of evenness of flow), intensity, and steepness of flow's ascent or descent (how flow fluctuates between free and bound flow—whether abruptly or gradually) (9:523).

The phenomenon of flow usually seems to be contained within a framework of a healing or deepening of personal insight. When flow is blocked, bound, set or misdirected, one may have backaches, or be unable to speak, or feel at "loose ends." When flow is locked into a characteristic pattern, binding freedom to move congruently, a person is usually hiding or defending his inner self or denying his inner space.

Being able to ascertain the degree of freeness or boundness of flow and to perceive where the body is blocking flow (the specific area in the body where the energy does not flow freely, causing the child to move in an inhibited, nonfluid, distorted manner) helps the movement therapist determine a treatment plan for the MBD child. The aim of the movement therapist is to have the child free or even restrict his energy, but appropriately to a given experience. As one works with the nonfocused, hyperactive child or the listless child who seems to have "given in to gravity," it is the flow factor which helps the child learn and gain control. There seems to be a positive correlation between a child's range of flow and his ability to inhibit impulse and delay gratification appropriately. When there is minimal brain dysfunction, distinct flow patterns emerge, expression is blocked and movement usually has a narrow range of energy expression. It is as though the child has imprisoned himself, protected by a wall of reliable motor responses. To work through such blocks and increase the child's range of response is one of movement therapy's goals. It is a difficult one.

Though it is noted throughout the literature that the individual has the ability to alter radically his perception of himself (5:3-53), often he will not perceive or will even deny that any change has occurred (5:10). Thus it seems that regardless of the completeness or faultiness of the body image, the human organism can be resistant to change. It is important then for the movement therapist to remain aware of the fearfulness and the anxiety as well as the low feelings of self-esteem often exhibited by the MBD and to plan experiences accordingly. Experiences should be presented to build the child's confidence by gradually expanding his repertoire. As he comes to trust the relationship and himself, he is able to give up the old, faulty patterns and to find that new and healthier choices are within his grasp.

Gravity, Weight, Balance and Postures

These concepts are thoroughly discussed and explored in all perceptual-motor writings, as well as more abstractly in dance. Their value is evident to both educators and movement therapists. It is usually from these concepts that the experiences forming the exercises prescribed in the standard perceptual-movement programs develop. Work on the balance beam, "angels in the snow" and various jumping routines come under this category. However, the movement therapist's work differs, inasmuch as she attempts to isolate the essences first of body weight, then of postures and finally of balance. The sum total of the successful integration of all three leads to an awareness of gravity and its constant pull on the physical self.

Force, Time and Space

Concepts which the average individual takes for granted, such as "slow down," "push harder" or "pull your laces" often are meaningless to the MBD child. Often the problem that the child is encountering with the application of a gross or fine motor coordination skill is related to his inability to experience and express range in the energy dynamics. In movement therapy the child is exposed to each of the elements separately, learns to develop a range and then is led gradually into combinations of the elements (the essence of movement quality and purposeful action). The elements are of time, of space and of force.

Movement therapy helps lead the child through activities in which he is able to experience and develop a range in each of the elements. In time, the range is a continuum from very slow to very fast, in force a continuum from very light to very strong, and in space a continuum from moving through space indirectly to directly. There is a second aspect to the space element, that of space as three dimensional. Work in this aspect is most crucial for the acquisition of later conceptual development leading into reading, writing and mathematics. Space is divided into three planes—1) the vertical or up and down plane, 2) the sagittal or forward and backward plane and 3) the horizontal or side to side plane. In each instance the child must experience the plane kinesthetically if he is later to internalize and generalize it. The physical experiences begin with the articulation and flexibility of the torso, which when not bound has the functional capacity to articulate in all three planes.

Specific work in the area of range in dynamics and space seems directly to affect impulse control, ability to sequence, ability to abstract symbols and conceptualize, and to a certain extent to form object relationships. The work of Rudolf Laban in movement description and analysis is essential to a thorough understanding of the elements of dynamics (which he named "efforts") (10). Anyone involved in creating or executing movement programs should know his writings.

Locomotor Moving

As the child begins to develop his range of dynamics, of flow, and has defined his body boundaries and articulated his body parts, he becomes ready to engage in gross motor skill organization. Locomotor moving (hopping, running, sliding, skipping, jumping, etc.) are the expressions of this organization. A progression is developed from simplest to most complex. This entails coordination of body parts, development of rhythmic structure and progression of the body moving in and through space from the lowest level to the highest level—that is, nearest to the floor (or gravity), gradually progressing up towards the highest level of space (or farthest from gravity). If each step has been successfully developed and experienced by the child, he

will discover naturally each skill for himself. Probably one of the most complex skills to discover is skipping. It relies upon the coordination of feet, ankles, knees, hip joint, torso and arms and upon a complex rhythmic structure (which is the organization of the force and time elements), and it occurs far from gravity (in the up, vertical plane of space).

The execution of a gross motor skill entails a high level of perceptual-motor integration. To both the movement therapist and a child in treatment, there is tremendous gratification in finally achieving such a skill. It often occurs spontaneously after many months of careful application of the movement therapy program. When it does occur, invariably there are parallel achievements occurring in the classroom. Following are two examples illustrating how specifically movement therapy was applied in work with MBD children.

Example I

C. was a five-year-old MBD girl, described as somewhat depressed and without pleasure. She saw herself as a fat, empty blob, graphically depicted by her figure drawings. Though her conceptual skills were extraordinary, and she could shift easily from perceptual to functional, her less developed motor skills and her lack of experience in using her hands were a great source of frustration for her. However, she was verbal and articulate, and so bright that much of the basic movement work directed towards helping a child to imitate could be bypassed. The essentials of moving could be dealt with almost from the first session. C. met with the movement therapist for 15 sessions, progressing from 15 to 30 minutes in length. Suggestions were made to the classroom teacher for certain carryover activities to be executed daily. C.'s major problem areas physically were:

1. inability to identify and control gravity and center of weight
2. inability to articulate bound torso and separate it from lower body
3. poorly articulated feet
4. lack of organizational ability leading to gross motor skills
5. poor rhythmic organization
6. high level of anxiety, affecting ability to sustain movement involvement.

C. was unable to hop, jump and skip accurately or with any fluidity and she could not vary the dynamics on her running and walking. If she was not "giving in to gravity" (an indication of her depression), she exhibited a slight range of free flow, but had little variation range of flow or control. Her energy pattern showed a disposition towards quickness in time, directness in space and lightness in force, with almost no range of opposite expression in any of the three elements. Because of the inconsistency of her range of development, her body was in poor performance condition. Much of the work in the movement therapy concerned itself with body tonus and flexibility, as well as the other constructs dealt with earlier in this report.

At the conclusion of 15 sessions some of the more outstanding observable changes were:

1. ability to become involved and focused in a nonfearful, nonanxious manner
2. flexibility of torso (spine) in all planes
3. ability to identify and duplicate voiced rhythm patterns
4. ability to moderate and control verbally directed flow and energy variations
5. ability to perform all major childhood gross motor skills in a relaxed, pleasure producing attitude.

The sessions would have continued, but G. was being moved to a normal class and school. At her last session, after saying goodbye, G. walked slowly out the door for the last time. She turned her head back, waved good-bye one more time and skipped happily down the hall!

Example II

The subject was an eight-year-old girl who had been in movement therapy for two years, seeing the therapist once a week throughout the school year. Her problems were much more severe than those of G., affecting her in every area of functioning. However, she made steady growth and progress in all areas, and parallel achievements were invariably seen in movement and in the classroom. Recently her classroom teacher had had great difficulty in helping her to overcome her "messy" writing. After weeks working patiently with the child, with no improvement and seemingly no comprehension by the child of what she was doing incorrectly, the teacher remembered something that she had seen the child perform in movement.

The teacher recalled that the child was able to move her body in a sustained, fluid, "controlled" manner, then switch with a verbal cue to a floppy, quick, indirect, "out of control" kind of movement. The teacher decided to try and apply the principle of "control" vs. "no control" to the child's writing problem. The teacher first asked the child to write with "no control," just as she had moved her body in movement. What the child wrote was her characteristic messy script. Then the teacher asked the child to write with "control," again stating, "just as you do in movement." For the first time the child displayed neat, controlled, appropriate writing. She no longer has a messy writing problem.

The child had at some point internalized a concept. She was unable to find the abstraction alone. In her instance, the careful guidance and awareness of the teacher brought the concept to cognition.

For movement therapy to be most effective it should ideally mesh with whatever program or structure it is part of, and become an essential element in a multidisciplinary approach. Also, there are several other considerations to be dealt with in designing an ideal program. They are described below.

Environment

One should attempt to work in as stimulus-free an environment as possible: bare floor, bare walls, blinds closed and no interruptions and uninvited observers. Props which may become part of the therapy should be hidden until used. Only furniture which will be specifically used for movement should be visible. The space should be well defined and quite contained for the early sessions. If the

conditions are less than optimal, focusing and attention become even harder to develop and sustain.

Length

The sessions should be quite short at first, gradually building in duration to no more than 20 or 30 minutes. Early sessions of 10 or 15 minutes are adequate. The therapist attempts to enlarge the child's span of attention. If the sessions build upon a child's ability, rather than presenting more than he is able to sustain, success will grow proportionately.

Number of Children

One therapist to two children is desirable in the beginning. For work with MBD children to be effective, it must be highly specialized, dealing directly with each child's particular needs. If three or four children must attend, one other adult should be present to help focus and structure the children. The other adult should not assist in the movement, for it becomes too confusing for the child to respond to cues from more than one person. The therapist must be able to build a strong, trusting relationship, and too many adults confuse the issue.

Once the early or the basic body image, sensory experiences and primary energy dynamic foundation have been established, both length and sessions, locale and even the number of children may be varied.

Therapist-Child Relationship

The therapist may initially relate to a child in any one of several ways. Her decision is based upon the child's overall behavioral functioning. The most primitive level is the symbiotic one in which the therapist holds and moves the child to develop a sense of the body moving. From this level, one is able gradually to progress to a parallel, or mirroring relationship, and finally one works towards helping the child move from verbal cues as well as from visual or imitative ones. To help strengthen the kinesthetic-visual modality, it is helpful to have children move for a turn, and then observe for a turn, if there is more than one child present. Often this method hastens a child's attempts at self-exploration and ability to master a dynamic on his own.

Structure of Presentation

Movement therapy in the early stages is addressed to isolated areas of the body. An effective method is to spend the first four or five sessions with an MBD child seated at a table, moving only the hands and the upper part of the body. The next step might be to work seated in chairs. The third step would be to move while seated or positioned in various levels on the floor. The most advanced stage would be to work anywhere in the given space, on any part or all of the body.

MBD children are often anxious, easily distractible and may have difficulties in conceptual comprehension. They seem to have difficulty in organizing and integrating their inner and outer stimuli. By presenting the movement therapy experiences within the structure as outlined above, the MBD child is afforded an opportunity to learn when and how to control and direct certain of his impulses. Gradually, as the child learns to adapt and to become adaptable and his control grows, form emerges within the movement context, thereby helping the child to gain understanding of himself and increasing his ability to integrate stimuli.

SUMMARY OF GOALS, HYPOTHESES AND METHODS

Goals of movement therapy with the MBD

- to help the child identify and experience his body boundaries (that physical entity from which all perception is recorded and expressed)
- to help each child master the dynamics of moving and expressing his feelings with an unencumbered body
- to focus the hyperactive child
- to lessen anxiety and heighten ability to socialize
- to strengthen the self-concept

Hypotheses relevant to goals

- Movement therapy experiences that improve the body schema and sense of self will increase the child's ability to focus and concentrate.
- Movement experiences that improve the body image positively affect the socialization of children.
- Movement therapy experiences increase the child's capacity for learning.
- A distorted body image or perceptual disturbance will manifest itself in the child's inability to master gross motor skills.
- By treating the body image or perceptual problem directly, the child will be liberated to develop the heretofore impossible skill.

Methods

- Experiences are developed and presented from the constructs of sensory awareness, body image, energy dynamics, flow variation and locomotor moving—body parts and boundaries are defined, a range in time, space and force is developed, dimensionality of space is experienced, and gravity and balance awareness are heightened.
- Experiences are presented initially in a small, contained area, developing from 15 to 30 minutes in length, with a minimum amount of children in a group, from a symbiotic to a self-exploratory relationship, with a minimum of speech and a maximum of movement repetitions.
- Experiences are developed and presented ideally as part of a multidisciplinary team approach.

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Body Movement Therapy and the Visually-Impaired Person

Jo Weisbrod

When I was working in the Washington, D.C. Special Education School, I observed that "normal" children thought of visually-impaired children as being "different." They developed fantasies about how the visually-impaired children had lost their sight and engaged in elaborate games reenacting what they imagined to have happened. Much of the content of these portrayals put the visually-impaired children further away from what "normal" meant to the majority of the children at the school. In this way the visually-impaired children became isolated from the others.

A new child was first observed as having a sight problem by the other children in terms of physical motion (not in terms of lack of or impaired vision). They noticed and commented on a slower speed, a kind of hesitancy, a body posture which is slightly twisted to the side and feet which tended to splay outwards.

I would like to generalize my experience with these children to visually-impaired people in general and to a discussion of how to use movement in working with this population.

Part of being able to work with visually-impaired people is to experience and understand personally how vision and its absence affects your own movements. Recently I took part in a blindfolded walk. I was led about by my partner. I experienced a new mode of motion which I now see as necessary for survival in a sightless world. I felt my hesitancy to move and my willingness to be still until helped to move. I felt the tendency to touch objects lightly and twist sideways to use my side rather than my front to meet what was ahead. My initial fear that my partner would not take good care of me subsided and I began to trust him. I found that I bent my arms in slightly and took smaller, shuffling steps. And finally, I tried to move aggressively out into space and discovered a deep fear which made me stop.

I do understand how all of these movement qualities are at first necessary survival techniques. I also have seen how body movement therapy emphasizing momentum, breath awareness and aggressiveness aids in the development of a special quality of experience. Visually-impaired and sighted people often lack this quality. A visually-impaired child learns very early that his movement is greatly inhibited and restricted and that he cannot enter into the usual active games of children his age.

Physical Momentum

We must take a closer look at the way we view movement and aid the visually-impaired person to lessen his "differentness" by using his physical momentum more

naturally. Body movement therapy is one way to help him accomplish this.

What do I mean by momentum? Primarily I am talking about the flow of energy and lack of residual muscular tension throughout *all* body parts. In this case, flow of energy refers to a full connecting, a fluidity of flexibility of the neural impulses which must take place for full, spatially and rhythmically clear motion. When energy flow is full, momentum is strong, so there is a sense of completion in a person's movements. There is a kind of grace and ease to the person, a naturalness.

When momentum is stopped or blocked, unusual movements emerge. Some who work with visually-impaired people refer to these strange and somewhat bizarre movements as "blindisms." They may be repetitious rocking, head rolling and arm jerking. Blindisms often lack the follow-through necessary for a sense of completion. Blocked momentum is usually connected with some kind of fear or terror which has incorporated itself in the body and externalizes itself in motion. Blocked momentum is a type of paralysis which must be remedied if the person is to achieve freedom of motion and expression.

Awareness of Breathing

A totally free and rhythmic use of the body is at all times linked with a good awareness of breathing. Blind people often breathe quite shallowly so many of their movements are hesitant, jerky and over-controlled. The extent to which breath affects movements cannot be overemphasized. The power of a movement is intimately connected with the kind of breathing patterns which a person has.

A visually-impaired person must learn to travel about his world with some degree of efficiency. One widely used technique to aid this learning process is mobility training. It helps the visually-impaired person use kinesthetic and auditory cues to acquire awareness of distances, placement of people and events, and other skills necessary for effective locomotion.

The body is also an expressive and creative entity in itself and not merely a vessel in which the mind flourishes and the self locomotes. Body movement therapy aids in the full integration and expression of the human self through awareness of momentum, the full use of breath and the development of a certain quality of movement I call "aggressiveness."

Ability to Move Aggressively

Most blind and many sighted people lack the ability to move aggressively. I do not mean violently or with hostility but a quality of being very definitely *in* a certain place. For me, it means that you are *doing* what you are *doing* with concentration. In a gestalt sense you are in the *now*. It includes an exact kind of strength and a sense of rightness about you where you are. For example, a bullfighter, as he moves the bull, is feeling a rightness. He knows very clearly where he wants to be and where he wants the bull to be.

Today we commonly see this quality in sports. At its finest, the Olympic Games, especially the track and field events, show us a quality of performance, an extra push. In a 200-meter sprint we get the sense of something very fine and difficult happening in a matter of seconds.

However, our culture and the lifestyles available to us generally have little to do with the development of aggressiveness. In many cases, it is considered undesirable. Aggressiveness is not to be relegated to "style" or verve. It is not self-confidence. This is a quality of life which must permeate a person and his movement if he is to survive in the fullest sense of the term. By survival I mean the sense of owning our bodies and being responsible for our actions and ourselves. How can we develop it?

Instead of giving classes and arbitrarily designated "movement sessions," we need to create a lifestyle which brings us into active and intimate involvement with our environment. In a sense, I am putting myself out of a job. However, until such a time, I am in the process of looking very closely at my techniques. I am extending those related to momentum, breath and aggressiveness and de-emphasizing those not central to its development.

Movement Therapy Sessions

Age, maturity and severity of handicap must be considered when structuring experiences. The exercises

themselves are chosen from dance, dance therapy, creative dance, dramatics, music therapy, encounter and gestalt psychology and physical education.

My goals provide an overall structure to aid visually-impaired people to more fully own, use and gain pleasure from their bodies. Movement therapy sessions are designed so the participants will: 1) explore their movement strengths and limitations and move more freely in relation to their handicaps, 2) increase their awareness of their movement potential, body image, gross motor coordinations and the full kinesthetic pleasure of motion,

3) reaffirm the positive aspects of their existing movement style while widening their range of movement responses in terms of their awareness of tension and relaxation, breath and metric organization and spatial concepts, 4) experience themselves as the creative center for their actions so they can contribute responsibly to group situations and channel all their impulses into a vibrant and relaxing release and 5) increase their scope of movement through the exploration of Body Universals. They are: a) weight—the heaviness or lightness of motion, b) breath—inhalation/exhalation cycle, inspirational aspect of motion, c) gravity—relation of the body and movement to the vertical pull, d) open/closed—body segments and the whole body in various aspects of openness and closedness (physically and psychologically), e) self/not-self—differentiation of inside and outside the body, f) front/back—relative values of forward and backward motion and g) right/left—exploration of opposition.

Activity areas which support these goals are: 1) movement fundamentals—strength, flexibility, endurance, unilateral and bilateral motion, balance, locomotion and leg rotation, 2) uses of energy-flow of momentum, 3) uses of rhythm—based on breath and inner pulses, 4) uses of space—directions, distances, dimensions and levels, 5) multisensory experiences combining movement with other senses, 6) relationship awareness with objects, images, self, others as individuals, partners, small and large groups, and 7) role-playing—creation of a physical and psychological mood using guided fantasy and self-directed internal journeys.

Basically these goals and activity areas are useful for any group of people. With visually-impaired people I emphasize certain aspects. For example, obviously they do not receive nonverbal postural and gestural cues, thus they must rely on auditory cues about what is going on around them.

For a sighted person, full communication involves verbal and nonverbal information. Clarity of expression and communication often includes a complex matrix of gestures and verbalization. Since the visually-impaired person is unable to see this matrix, communication is blurred in a real way. The meaning is smudged. To make up for this lack, they develop a finely attuned listening ability. Voice tone, inflections and emotions in word choice become the avenue through which they receive many of the nuances sighted people receive through nonverbal gestures.

Visually-impaired people are also very sensitive to the use of musical instruments and recordings, body sounds (clapping, finger snapping) and spontaneous vocalizations in song. These techniques aid them to move more freely and express their feelings through movement.

Also, I have found the role of the "announcer" to be helpful. In groups, one way to clue visually-impaired people in on what is happening and the nuances of quality is to have a sighted person announce what is happening. With children this greatly affirms their moving image of themselves. With adults this aids in a freer mode of moving. The role of a "guide" is used in many ways, not only to help them maneuver about. For example, in an adult group we were talking about the importance of feeling "roots" in a psychological and physical sense. We related it to a sense of being grounded and centered. I gave the direction to get in touch with a sense of roots in the body. Several got the idea and really "dug" into the ground. However, one young woman (visually-impaired) could not get the idea, so one by one each member of the group verbally guided her through their experience of roots. In this way she shared a full sense of "rootness."

Much of body movement therapy and its success with visually-impaired people depends on the development of trust. Obviously, if the therapist allows the person to injure himself, a good rapport will not evolve. Thus the therapist must pay attention to the movements required by whatever experience is presented and plan accordingly to insure safety and ease of motion.

Initiating aggressive movement through space is particularly difficult for a congenitally blind person. The creation of a known and well-explored space is essential to a sense of safety. One easily learns that one large running step equals two or three short walking steps. With practice, a well-defined, consistently-shaped space can be used to help enlarge the use of space.

Visually-impaired people are often plagued by fantasies and fears related to their lack of sight or poor vision. Active role-playing and the acting out of dreams through movement can be one outlet for many such fears. For example, Henry, an eleven-year-old, was concerned that because of his poor vision he would not have any friends and would not be invited to any parties. He had created several imaginary friends to the detriment of his real friendships. He was moving very quickly into a make-believe world where everyone liked him. One day in movement session he acted out going to a party. There he danced and talked with friends but was also rejected by a girl he liked and became sad. Following this event he began an entire series of "sad" dances. Henry had begun to face his fear and to deal with his sadness.

Selina was a 10-year-old blind girl who was quite outgoing. She tried to join into many of the games and activities of girls on her block. The harder she tried, the more frustrated she became. Her breath became tighter and more shallow. One thing in particular really bothered her. She kept losing the ball or line marker in the games. She eventually began to feel that if she could lose an object so easily, maybe she would get lost and nobody could find her. She began to worry incessantly about being lost and never found. During this time we had been doing a lot of deep breathing. One day she sat very still and did not speak. I asked her what was going on; she shook her head. I left her alone and after a while she began exaggerated groping motions. She called her mother for help. Her breath quickened. I did not answer because I felt she had to work this one out on her own. I trusted what was a kind of basic strength within her. She started crying and crawling across the floor. Finally she started a deep breathing sequence I had taught her and said, "I am really all by myself. I can find my way on my knees. I am not lost."

George, a teen-aged boy, had lost one eye as a child and

a year ago had lost the sight of the other eye. Violent and angry parents had caused both losses. He became deeply afraid that someone would come up to him and beat him up. The combined efforts of an understanding teacher, a blind volunteer worker and myself in movement sessions helped him develop extremely acute hearing so he could hear someone coming and defend himself. In movement sessions we focused on moving aggressively so that he developed his physical and psychic strengths until he could defend himself well.

Marilyn, who had lost the sight of one eye and had poor vision in the other, feared that birds would come and pluck out her one useful eye. So she played the role of the birds, then of her good eye, and finally of herself. She discovered she could protect herself by shouting and striking out with her arms at the birds. She began to get in touch with her ability to move aggressively.

The one-time release of such fears will not solve the problem, but it allows the person to confront the fear, give it a name and begin to deal with it.

Sharon, a 40-year-old totally blind woman institutionalized for additional emotional problems, could not initiate movement. When left alone, she tended to stand still. This is a common tendency among congenitally blind people. They lack momentum and initiative to move out on their own. In conjunction with this lack is a tendency to be over-cooperative. It is much easier to cooperate with sighted people than to develop one's own momentum and direction.

I worked with Sharon individually and in a group for several months developing her awareness of her need and capacity to initiate movement. At first we did standard modern dance exercises which evolved into sensory awareness, focusing on tension and relaxation. She did not stop fearing accidents, but she got in touch with her own momentum so she could spontaneously reach out and use space around her in a larger, freer way.

In my estimation, a body movement therapist must be aware of several important areas of concern in order to work with visually-impaired people:

1. the effect of loss of vision on movement and relating abilities in general
2. the necessity of focusing more specifically on the use of momentum, breath awareness and aggressiveness as techniques for a more integrated development of self-confidence with visually-impaired people
3. the value of having a safe place for visually-impaired people to focus on a healthy and full use of their bodies, and an atmosphere which allows for a quality of relating with others that includes realistic and honest communication.

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Therapeutic Values of Dance Education for the Deaf

Pete Wisher

Literature in the area of dance therapy for the deaf is almost nonexistent. Neither dance therapy nor successful programs in schools and classes is readily available for hearing-impaired persons. In order to discuss the value of dance for the deaf I must therefore rely heavily upon 1) my experiences in dance education with the deaf over a period of 18 years and 2) observations expressed by the deaf.

Since no generally agreed-upon definition of deafness exists, the exact number of hearing-impaired persons in the United States is a debatable figure. The extent of hearing impairment varies from a mild loss to profound deafness; statistical estimates vary depending upon how one differentiates between the deaf and the hard of hearing. Given this uncertainty, and upon the basis of the limited data available, I estimate that there are approximately 2,000,000 hearing handicapped in America.

Only recently are we beginning to realize the tremendous values inherent in dance for the deaf population. Some of the most important benefits are listed below. Although the therapeutic components discussed are intrinsically related, they are treated separately.

Aspects of Deafness

Social

Deafness is considered a cause of isolation from the hearing and also of isolation among the deaf themselves. Inasmuch as dance *per se* becomes a social experience it tends to lessen this feeling of isolation. It also provides an environment which promotes the acquisition of such positive attributes as consideration of others, acceptable behavior, unselfishness and promotion of group solidarity.

Intellectual

The results of scholastic achievement scores for the deaf when compared to those of their hearing counterparts are grim. One study indicates that the deaf are retarded from four to seven years behind their hearing peers (5). This condition is essentially because: 1) deafness interferes with normal acquisition of language, both oral and written (1, 2, 3), 2) communication, regardless of method, seems to have inherent difficulties with respect to intellectual development; and 3) current tests and testing practices cannot adequately assess the educational attainments of the deaf. A study by Myklebust (2) indicated that the deaf have certain deficiencies with respect to abstracting and conceptual ability. The exploration of movement and solving movement problems can surely assist in the correction of these two deficiencies.

With spoken language deficiency a recognized concomitant of deafness, the area of dance becomes more significant in the learning process. Many new words are learned in mastering a poem, a song, a story.

Emotions, ideas, meanings can be externalized through appropriate movements. Much has been said about body language. For the hearing this is an interesting topic for discussion; for the deaf it is indispensable.

Physical

As in any other segment of society, there are multiply handicapped persons in the deaf population as well. In general, I have noted no great differences in the physical structure of the deaf when compared to the hearing. However, student surveys have indicated that many schools have very limited or no programs in physical education or health for the deaf. As a result the deaf are weak in neuromuscular skills. Dance in conjunction with physical education activities could contribute much to improving this apparent weakness.

For years I have been reading and hearing that the deaf have poor balance. This conceivably is true where the cause of deafness affects the balance mechanism in the inner ear, but most deaf people I have observed in physical activities do not exhibit this trait.

Emotional

Conceivably deafness can lead to emotional problems. I have not worked with many students I would categorize as emotionally disturbed. However, studies have reported that the deaf are socially immature, have a rigid standard of behavior, resort to impulsive behavior, are egocentric and demonstrate extremes in behavior ranging from complete withdrawal to outbursts of rage (3, 4). Through dance the participant has a means of reducing tensions resulting from frustrations caused by deafness. And the fact that positive emotions can be stimulated through dance should not be overlooked.

Many students have stated that dance experience has given them a confidence which they never had before; they acquired feelings of personal worth which applied to

their relationships not only with other deaf people but with the hearing as well.

Spiritual

I have observed over the years that many hearing-impaired individuals have a keen interest in religion. This is vividly portrayed when they perform dances in any way related to worship. Religious feelings that may be difficult for the deaf to express verbally can sometimes be more readily communicated nonverbally through body movement.

General Considerations

Accompaniment

An essential aspect of dance for the deaf is the accompaniment, both in learning new rhythms and in performing movements. One instrument—the drum—can be used satisfactorily with individuals having different levels of hearing loss. All can feel its beat. All types of rhythms from basic to very advanced forms can be experienced by the deaf. Amplified music is often used to good advantage, especially when some of the participants possess any residual hearing. Sometimes it seems that even the profoundly deaf have an awareness of recorded music being played. How this is perceived is unknown to me and, of course, varies with each individual. In dances where following an audible musical pattern is important, the profoundly deaf often depend upon the hard of hearing for cues.

Music only serves to complement and supplement the dance and is not the central concern. Dances are sometimes performed in silence; feelings and moods set the quality and duration of appropriate movement.

Tactile Cues

The deaf, because of their hearing loss, seem to develop an acute awareness of vibrations. Not only is this useful in teaching dance, but it is also satisfying for many deaf people to experience physical contact with musical instruments or recorded music. It has often been reported that the deaf dance to vibrations, specifically those that come from the floor. This is folklore. While standing still one could possibly receive vibratory impulses but once one starts to move this contact is lost.

Sign Language Dances

The deaf have made a significant contribution to the creative arts by developing dances based on the abstraction of signs used in communication. Through this means poems, songs and stories can be "danced." Dance is sometimes defined as "communication through movement." In this light the deaf dance all their lives, since their communication is to a great extent based on movement.

Speech

It is probably correct to state that there is more emphasis, budget, personnel, equipment and class time placed on speech and speechreading than on any other single item in the education of the deaf. Occasionally other important considerations in education suffer because of this centralization of effort. The individual's total development is sacrificed in the interest of acquiring excellence in speech. For some, intelligible speech is impossible to attain.

I do not mean to imply that speech is not a worthy objective; all must contribute to this effort, not the speech teacher alone. The relaxed environment of a dance studio is an excellent place for the improvement of speech; new words are learned; poems are recited and danced; songs are sung. It would be difficult for me to recall a single dance class in which I did not hear audible counts, or words to songs and poems.

Communication

The single essential factor in understanding the deaf is their method of communication. There are several:

1. Oral communication. Communication is through speech, speechreading and the use of auditory equipment.
2. Fingerspelling. Each letter of the alphabet has a corresponding position of the fingers. All words are spelled out.
3. Language of signs. Gestures are strung together in a syntactical system to provide a visual system of communication.
4. Cued speech. Some institutions and individuals are now employing a form of communication which relies

heavily upon speech and speechreading and is augmented with manual cues.

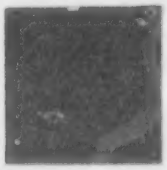
5. Simultaneous method. The language of signs, the manual alphabet, speech and speechreading are employed together.

I feel that the simultaneous method is the most effective means of communication with and between the deaf. I have never been able to communicate fully with any deaf student or adult orally. If total development of the individual is our aim, then the most effective, most practical means of achieving this end is through total communication.

Anyone presently contemplating either teaching or working in therapy with the deaf should acquire facility in manual communication. Classes in the language of signs are available in most large cities, in schools for the deaf and at some universities. Several universities have accepted competence in the language of signs as a means of satisfying a foreign language requirement.

Visual Dependence

The deaf naturally rely heavily on the visual in all facets of their lives, especially the educational and social aspects. Unless special arrangements are made, movies, television programs, concerts, radio are practically meaningless. They therefore tend to gravitate to activities which depend to a great extent on things visual, both for comprehension and for satisfaction.



Dance could play a much more vital role in important social functions in the lives of the deaf—religious services, marriages, funerals, births. Playing "Here Comes the Bride" at a wedding is meaningless to the deaf participant.

Conclusion

The entire field of deafness is in dire need of study; the field is rife with misunderstandings and prejudices. All those involved with the deaf must be able to communicate effectively with them. There is no substitute in this regard for competence in American Sign Language.

Since the deaf are limited in their avenues for learning and expressing themselves, the place of dance as a learning tool and as a social and therapeutic experience becomes vital. Dance programs for the deaf are slowly making advances, but currently need a great impetus so that all the deaf can benefit from them.

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Dance Therapy with Special Children

Elizabeth Polk

One of many definitions for dance and dancing is "body talk." My body talk speaks of joyful living. My goal as a dance movement therapist is to teach this language to "special" children.

"Special" Children

They are labeled "special" because they are diagnosed emotionally disturbed or suffering from learning disabilities. They are those who are hyperactive and aggressive or apathetic and withdrawn. Some move dynamically but lack fine motor control; others get lost in space and won't move; still others move in a bizarre manner. Many are diagnosed schizophrenic. They withdraw from reality into a world of their own. The assignment of the dance therapist is to bring them back into the normal world, to help them be like other children. Children love to move, they are inquisitive, they learn through play, they test their elders, they need peers, they want to please, they need approval and love, they need to trust. "Special children" have the same needs, although they can't express them. Their selfhoods are buried under layers of fears and other problems which appear to paralyze their minds and bodies.

I work with such children throughout New York City, in two special day schools and one residential treatment center. The staff includes social workers, therapists, psychologists and doctors who are in charge of diagnosis and medical treatment. As I work in a school environment, my sessions are called "classes." We meet in a small gymnasium and in adapted basements because we need space. The youngsters, ranging in age from five to approximately twelve, are my "pupils" and I am their "teacher." I see them either individually or in small groups. The basic difference in the teaching approach is that the group sessions are structured and the individual sessions are unstructured.

The success of individual sessions depends very much on my relationship with the child. He must feel safe and trust me as I become a playmate and a mother figure and at the same time remain the teacher.

Sessions with "Special" Children

I prepare these sessions by displaying instruments, props, records in smorgasbord fashion. I watch for the child's reactions, take my cues from him and join him where he is and in what he is doing, slowly developing the situation into a therapeutic and purposeful one.

Sometimes we might begin by just resting, lying on a mat and doing nothing or listening peacefully to a record. Then we might both punch the punching bag, help each other to feel our muscles with push-ups, try headstands to see the world upside down and attempt other stunts. Or we hold each other and play see-saw or swing or use props. We might learn to balance on the balance beam or establish spatial concepts like through, over and under by crawling through a hoop, or over and under a table. I keep this going as long as the child's attention span permits. If I have

music accompaniment, we both have to listen and let the music guide us into a certain rhythm and finally signal us to stop.

As the child's self-concept improves, his attention span lengthens and I find more and more cause for praise. Praise is a wonderful medicine—it gives confidence and self-esteem.

If a child compulsively sucks his thumb, manipulates an object or flicks light switches, I try every possible trick to modify these repetitive habits. I give him instruments like bells, castanets and maracas that must be played with *both* hands and are attractive enough to entice the child to use his hands for normal activity. I reduced constant light switching by instituting a surprise practice, as described in the following case study of Pim who was eight years old when he was admitted to our residential treatment center.

The Case of Pim

Pim had had outpatient clinical therapy under the diagnosis of childhood schizophrenia. In his case, this meant that he had no investment in human relationship. His only involvement was with mechanical devices. He had no concept of his own body, no sense of his own bodily functioning. He did not know how to socialize verbally and was fearful of body contact.

When I first saw him, he was a lump of flesh, slouching around like a very tired old man unable to lift his feet, seemingly oblivious to me, the children, even the room. But one thing he saw: the electric outlets and switches along the walls. He would handle them, play with them and then, without a sound, slouch out of the room. This repeated itself for weeks. When he started to notice me, I arranged to have him alone, just once. I placed some wooden blocks around the room and tried to coax him to step on and off them. Reluctantly he would stand still, make an attempt and walk out again. The effort to lift his feet was too much.

The following summer I had Pim in individual sessions and we got to know each other much better. The first time he still tried to ignore me. For almost 10 minutes, he switched off and on every light switch he could find. After that he took a toy car and started playing with it. Watching him, I sat down on the floor, took another car and started playing as he did, only using my legs as bridges and tunnels. Finally he noticed me. He stopped next to me and very clumsily, fighting with himself just to bend his knees, he sat down and watched.

I took off my slippers and socks and started to show him my feet, handling my toes and comparing them to my hands and fingers. I explained to him the purpose of his heels and toes and introduced him to the mechanics of the foot. He became interested and removed his socks and shoes. I am sure this was the moment when Pim first discovered his feet and their function.

My next goal was to make him use his feet. I did this by playing a game with him. We stood up and I asked, "How high can we reach? Can we reach higher?" As I pointed out the mechanics of his feet when involved in stretching, he began to use his feet consciously: up—down, toe—heel.

Our next session was a catastrophe. I had anticipated continuing where we had left off the last time, so I played a record with a happy walking rhythm. But he seemed determined to annoy me and to test my patience. I reached my boiling point when he tried to break the arm off the record player. I jumped at him furiously, seized his hand and yelled at him. That did it! He attacked me verbally and walked out, slamming the door.

I was very disappointed in myself and feared that he might never come back. But next week Pim came as if we had never had a run-in. After the usual inspection of light switches, he was ready to work. He played with me: heel—toes, heel—toes. I put a record on and, inspired by the music, he began running and tiptoeing. He obviously enjoyed himself.

It did not last long. Soon he started playing with the light switches again. Then and there I got an inspiration. I said casually, "Anybody can turn these switches on and off by hand. I can do it with my feet." He was stunned. I lay down, got into a shoulder stand and used my toes to switch the light. He was intrigued. Very clumsily he sat down on the floor, then tried to find his position toward the wall. His lack of correct perception of his position in space made this simple task a problem. He allowed me to help him lie on his back and for the first time lifted a leg. I felt triumphant! He kept on trying and again allowed me to help him until he finally reached the switch with one foot.

Never again did I permit Pim to use the light switches with his hands when he was in my class. By the end of the summer Pim did a fine shoulder stand, kneeling and lying down with ease.

Group Sessions

Difficulties like Pim's are best handled on a one-to-one basis, while problems such as social maladjustment are better treated in group sessions.

Unlike the unstructured individual sessions, my groups are structured. The children come with their teacher in groups not larger than seven. The structure demands assigning each person "his" place. This place is a certain seat on a bench, chair, pillow or floor mat. It is the starting point for all subsequent activities and the point to which everyone returns.

Having a special place gives the child a sense of security. Everyone learns to respect the other person's place and thus learns to respect the other person. This sense of security is so important that they practice leaving and returning to their places in many different ways, making a game of it. These games do double duty; they develop orientation in space as well as directionality.

If the situation permits, I start both kinds of session by making music with the children, using rhythm instruments, drums or a record. This is one way to develop listening and responding, prerequisites for any kind of communication.

There is also another use for drums. The children's pent-up frustrations and aggressions are eased when they can beat their anger into the drum. In due time this violent beating subsides and gives way to rhythmic drumming. A punching bag also serves as an anger outlet.

Balloons can take the place of the punching bag for the more inhibited aggressor. I encourage them to make fists

and punch the balloon boxing-style, "one to the right, one to the left." The balloons react by gently floating away and after a while the child's forcefulness and tenseness is eased and turns into playfulness.

The hyperactive ones chase after the balloons, but calm down as they learn to concentrate on balancing the balloons on their palms and arms. The apathetic ones become interested and start to move faster in space.

Visual perception problems and poor body image are some of the causes of learning disabilities. These too can be improved by playing with balloons. The children develop body awareness as they consciously toss the balloons with different body parts, like their head, shoulders, knees, feet and elbows. They also learn to focus as they juggle the balloons in the air, to keep them from dropping to the ground.

Sometimes the balloons can't be used either because the children are afraid to handle them or because they destroy them. In this case a large beachball serves well for some of the exercises and rhythms.

All these exercises, accompanied by music, result in a sense of joy and freedom of movement. They lead into bending, stretching, lifting, turning, twisting and dancing.

Whether using balloons or balls or other props, my purpose is to involve the children with something outside of themselves, something that catches their attention and motivates them to move in an enjoyable manner. Hoops, paper streamers, scarves, puppets, jump ropes are some of the props I always have on hand. Most of the children I work with have some kind of coordination problem in addition to their emotional difficulties. Any one of these props can be used to help correct these difficulties.

Rope jumping, for instance, not only helps with gross motor coordination and rhythm but is also a game, symbolic of happy childhood days. All youngsters who were deprived of a normal childhood recapture some childhood happiness as they join in jumping rope and singing silly counting rhymes.

I often have the children play musical chairs. It must be adapted to the special child so that no one is eliminated. This game is sheer fun if every player has a chair because there is no motivation to compete. Disturbed children have to face competition every minute of their young lives. It makes them tense and angry, and alienates them from their peers. They don't need alienation; they need friends. To help them with their social adjustment, I replace competition with challenge.

Group challenges help the children develop a team spirit. Playing in a rhythm orchestra, marching in different formations, building a pyramid, performing a group dance—all are group experiences which give a feeling of success, a feeling of pride in belonging.

It is a major task to lure the withdrawn child out of his isolation into a group, and to help the domineering child adjust to restrictions and group rules. It can be accomplished if the group atmosphere is happy; if laughter, music and movement work together, the joy becomes contagious.

The problem of human relations must be handled constantly. Partner activities and couple dances help the children relate to each other and overcome jealousies. In taking turns and changing partners, every child dances with everyone else.

One of the most successful group activities is role-playing and dance-acting. The class dances its own creations or acts out familiar stories like *The Wizard of Oz*. The scarecrow's loose movements, the tin man's stiff joints, the lion's tears, Dorothy's skipping and the bravery and ingenuity of Toto serve many therapeutic purposes, emotional and otherwise. One of my children was so inspired by his part and the music that he did something he had never done before—he skipped. He skipped "off to see the Wizard, the wonderful Wizard of Oz."

This is one of many success stories. It is the summation of many such small successes that enables the child to leave the special school and return to society.

As the child departs, the dance therapist recalls the hours of individual and group sessions; the child's joy in learning to move freely, in making friends, in feeling secure and loved; the initial shyness yielding to gregarious behavior; belligerence changing to self-control—the child's development of self-assurance and growth into a more fulfilled person.

RELATED MATERIAL

Wake Up! Calm Down—Through Rhythm and Dance. (LP record, available in cassette also). Produced by Elizabeth Polk. Distributor: Educational Activities, Inc., P.O. Box 392, Freeport, N.Y. 11520.

A Movement Therapy for Older People

Eva Desca Garnet

Health must be one of the joys of life
as no other joy is possible without it.
Thomas More

The above quotation is particularly meaningful to older people, most of whom have one or more chronic diseases. For not only is the maintenance of health the *sine qua non* of a satisfying life, but the vulnerability of the elderly to illness and disease endangers their independence, if not their very existence. Any illness can rob an older person of the minimum essentials for independent living and catapult him into the debilitating milieu of a hospital or nursing home.

A recent government study stated that, "The older population is essentially a low income group. Inadequate income is a major contributor in every area of concern: housing, nutrition, transportation, socialization, recreation, etc. Many have lost the companionship of their spouses"(1). As the fears for health and security become transformed into anxiety and depression, they pave the way for a whole train of somatic and psychological ills.

In a discussion of therapy for older people, we must recognize at the outset that we are not talking about a small percentage of people who have the misfortune of being ill. We are talking about 21 million men and women who have had the good fortune of living a long life.

My approach to movement therapy is the result of of 12 years. The approach a therapist uses depends upon the goals to be achieved, based on the needs and desires

(physical, psychological and social) of the individuals and the group. The approach may be modified because of setting.

The elderly participants in my groups have been men and women between the ages of 60 and 95. Many have attended weekly classes for a period of three years, and there are still some people participating who were members of the original group in 1960. Because the physical aspects of aging are so pronounced, I use a somatic rather than a psychological emphasis in geriatric movement therapy. (Psychological issues a geriatric therapist might deal with include fear of dependence, death or abandonment.)

The Process of Aging

Aging is a developmental process (2). All who are fortunate enough to live finally enter the senescent stage. Consequently all the handicaps and diseases that people are heir to are represented among the aged. This includes all the categorical handicaps: the blind, deaf, mentally retarded, etc. The diseases that head the list are cardiovascular: essential hypertension, athero- and arteriosclerosis, and heart attacks. These are followed by arthritis, diabetes and nervous disorders like Parkinson's, cerebral-vascular accident and depression. Indeed, a combination of disease, injury and stress results from the process of aging.

For simplicity we can say there are two kinds of clientele for the geriatric movement therapist. These are the "well aging," who by their own description have two or fewer chronic diseases (9), and the chronically ill. The former live in the open community, the latter in sheltered communities. The well aging may fill their leisure time through organized activities offered by adult education, parks and recreation programs, and senior citizen clubs and centers. The second group, those who are physically or mentally impaired or both, are mostly in retirement homes or some form of medically supervised facility. Here, with the shrinkage of "life-space," activity comes practically to a standstill. Most of the participants in this group are in some form of constant distress and seek relief. Their need for ego support is greater than that of the first group. Different as these two groups may be, they have a common need for therapeutic support.

Most older people develop the habit of inactivity, a habit difficult to overcome. In order to motivate them to participate in movement supplement, the movement must be geared to bringing them pleasure rather than discomfort and to fulfilling their basic instinctual needs(7). The therapist helps them to meet their needs in the following ways:

1. By supplementing movement and sensory deficit, a physiological need is fulfilled.
2. By the physical safety of the movement and the psychological safety of the presentation, an ego need for security is filled.
3. By promoting a feeling of group consciousness that grows out of a helping relationship, a feeling of belonging is achieved.
4. By promoting a congenial, supportive environment in which a group laughs easily at the same things, a participant changes his frame of reference from fatigue and depression to relaxation and exhilaration.
5. By acceptance and accommodation of each person's limitations, an atmosphere is created which facilitates the recognition of each person's unique achievements.

It has recently been demonstrated in experimental studies that complete sensory deprivation for a period of 30 hours causes hallucination in healthy young athletes. This helps us understand the plight of older people who are experiencing sensory losses. The sensory impairment of increasing blindness, deafness and loss of taste buds, and particularly decrease of the tactile sensations of affectionate relations and loss of kinesthetic sensations for lack of activity, add up to a massive sensory deprivation. The message is clear. We cannot restore the lost senses, but we can supplement sensory stimulation through modalities that are less impaired, and we can support those that still function, if we wish to help older people avoid hallucination and disorientation caused by sensory impairment.

Movement Techniques

The movement techniques I use include a wide range of flexion and extension of the axial joints and extremities, through contraction and stretch (or relaxation) of all important muscle groups. The movement sequences employ the rhythmic use of swings, falls, suspensions, twists, relaxations, stretches, bends, pushes and pulls. These are done in all directions of rotation, circumduction, adduction, abduction, elevation and depression of the different parts of the body. Studies are choreographed for physical and esthetic satisfaction through the use of variety and contrast. Music is used as a resource rather than as an accompaniment.

The judicious use of both relaxation techniques and vitalizing techniques is important. The relaxation techniques are motor responses giving in to gravity; the vitalizing techniques involve limited use of isometric contractions(8). The dynamic relaxation that results from true swings, i.e., fall, rebound and suspension, and the natural stretch that occurs in an isotonic movement reduce tension. But *residual tension* can only be relieved by what Jacobson calls *"progressive relaxation,"* which is passive(5). This principle is adapted to meet the needs of the participants.

The purpose of all the activity is to stimulate the neuromuscular mechanisms. Thus the subject matter

remains the same but the applications differ. As an example, let us take the kinesthetic pleasure of a movement rebound. In a fragile group it may be limited to the feeling in the shoulders resulting from the backward swing of the arms, while in a more vigorous group the experience of rebound is enjoyed in the muscles of the lower back as the whole torso bounces rhythmically.

The participants perform movement combinations which are composed to 1) meet physical needs which stimulate improved somatic feelings and 2) meet psychological needs with a whole spectrum of feelings, from ease and humor to vitality and beauty. Gentle body movement, which is in harmony with the needs of the functioning systems, stimulates an infinite chain of actions, reactions and interactions (3). At the tissue level, the improved physiological balance and relief from tension lasts for hours. These feelings are matched at the conscious level by increased vitality and well-being.

The sense of touch and the kinesthetic sense are the key modalities in the therapeutic movement experience, but the senses of seeing and hearing help make it possible. The participant sees the therapist and hears the verbal accompaniment of instruction, encouragement and reinforcement. This method bypasses failing memory. When necessary, one can also bypass a vision or hearing deficit as one modality takes over for the other.

All movement techniques are modified to the concept of *tolerance*(6). Any activities expected of the participant are well within his capacity to experience or perform without pain or strain. The stress of gravity on the participant is limited at the outset by the condition that movements are initially performed in a straight-backed chair. From this point on, all the movement is kept within the physical tolerance of the individual. This is insured in three ways:

1. The movement combinations and the sequence are arranged within the constraint of tolerance.
2. Most participants feel their own limitations and do not go beyond them.
3. The therapist learns to pick up subtle cues of fatigue, stress, impatience, disinterest, difficulty and pain or evidence of interest, pleasure or interaction and responds to the individual or group as a whole.

With his physical and psychological safety protected, the participant can enjoy the dynamic group experience of the class without forfeiting his individual needs.

The good feeling the older person experiences during movement therapy does not arise solely from the immediate sensations of pleasure from relief of restricted movement. It is often linked to the muscle memory of past events through "reverberating circuits of association"(4). A swing that feels free may awaken and hook into the kinesthetic memory of youthful feelings that, rekindled, reinforced the carefree experience.

After participating in a chain of hands that gently pulled him to and fro, a wheelchair patient with residual stroke said, "I feel a surge of life." The tactile experience of receiving rhythmic pulsations through the hands was described, "It makes me feel secure." Still another patient commented after a slow luxurious movement of the shoulders, "It makes me feel beautiful."

This variety of stimulations results in emotions that produce a sustained mood of well-being. In this sense, movement therapy must be regarded as a feeding of ever waxing and waning needs, not as a prescription hastening the cure of a disease.

Training for Dance Therapists

It is probably safe to say that formal education follows social need; i.e., there is a need for dance therapy, therefore there are curricula designed to fill this need. This is increasingly true of therapeutic movement for geriatrics. While dance therapists can adapt their professional experiences to serve the needs of the average geriatric participant, the size and scope of this population warrants additional specialized professional training. Where a specific course in movement for the aged is not available, dance therapists and students who wish to work with the elderly would derive considerable benefit from selected gerontology courses. There are several gerontology centers at universities throughout the United States. As gerontology is an interdisciplinary subject, it attracts a variety of professionals who are encouraged to apply gerontological concepts to their own fields. Ultimately, theory and skill must be applied to working with older people, and it is in the *experience* of working with older people that one becomes an effective geriatric movement therapist.

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Training and Professional Status

Part V

Curriculum Development in Dance Therapy

Sharon Chaiklin

As a developing profession, dance therapy is faced with the problem of instituting the standards and ethics which all emergent occupations must establish if they are to survive as professions. Webster's defines a profession as:

a calling requiring specialized knowledge and often long and intensive preparation including instruction in skills and methods as well as in the scientific, historical or scholarly principles underlying such skills and methods, maintaining. . .high standards of achievement and conduct, and committing its members to continued study.

Methods based on theory are the foundation on which any human service profession must be predicated. This basic learning must be imparted to those who will be its practitioners and call themselves part of the profession. Dance and movement therapy is still building its theoretical foundations. There is, however, enough knowledge to demonstrate that there now exists that specialized base which a profession requires. The development of a high quality curriculum is presently an urgent need of the dance therapy profession.

There are many ways to approach learning and professional preparation. To prescribe a single route would be folly, for it would narrow the potential of dance therapy; on the other hand, it is necessary to take initiative in setting criteria and standards. As with any profession, all standards are in process—they must be worked upon continually. No profession should ever be satisfied with its self-definition and dance therapy is continually redefining itself. Since its inception there has been concern with the following questions: What experiences led to the development of those earlier practitioners who struggled alone? What background knowledge and skills are important to the field? The exploration of these questions led to current thinking on the core knowledge needed to practice dance and movement therapy.

Programs in dance therapy can be formulated on undergraduate and graduate levels. The purpose of an undergraduate program is primarily to prepare for more advanced learning. In visualizing what the components of such preparation might be, it was found that the basic experience common to those already recognized in the field of dance therapy is a strong dance background. Students must come with a deep knowledge of the meaning of movement as a creative experience.

That everyone moves does not mean everyone can use movement as a therapeutic tool. One must have gone through the following experiences: learning to discipline the body and being aware of the difficulties involved; learning how movement flows in the body; attempting to communicate an idea or feeling through improvisation and choreography; moving with others and becoming familiar with how other people's bodies work; analyzing movement and understanding basic dance concepts; trying to organize all this material by teaching it to others. One must be able to answer the question "why is dance important to *me*?"

Undergraduate Programs

The undergraduate years should be spent in exploring movement and a broad base of knowledge in other fields. While a dance therapy student should have basic proficiency and understanding of dance as a performing art, the focus is not on the mastery of technique. Movement should remain organic to inner experiences. While structured classes in ballet, jazz and other forms are brought into service, modern educational dance should be the core of dance training. Other experiences which can be helpful in developing awareness of oneself in relation to one's body are ethnic and folk dance, tai chi ch'uan, relaxation techniques, sensory awareness and yoga. Physical experiences such as climbing, caving and boating and awareness of all that life can provide expand our individual range of movement experiences on many levels.

It is also important that a student gain a sense of the physiological and mechanical elements in body movement. Dance therapists often work with people who have physical problems of both organic and psychological origins. Understanding how the body works, anatomically and physiologically, is of immense value in aiding others to be aware of their bodies, understand how they compensate for their difficulties and realize what are functional problems rather than structural disabilities. Familiarity with anatomy, physiology, applied kinesiology and body mechanics is therefore necessary. Techniques that apply this knowledge, such as the Alexander Technique(1, 2),

relaxation principles based on the work of Jacobson(3, 4) and Selver(5) and principles of massage are all applicable.

Dance therapy involves understanding human behavior. One needs to learn about individual dynamics, family interaction and the influences of society on the individual. Courses in psychology, human development, anthropology and sociology are recommended. These should include: human growth and behavior, adolescent behavior, abnormal psychology, group dynamics, psychoanalytic theory, theories of personality, communication studies, cross-cultural and urban studies and symbolic interaction.

These three areas—dance and movement, biological study of the body and human behavior—are fundamental to dance therapy. It is the integration of this knowledge that results in the uniqueness of dance therapy and practice. An "Introduction to Dance Therapy" course should focus all this material into a usable structure. The course might include readings in dance therapy and awareness of various approaches, field trips and a field work placement, as well as beginning to work on movement expression and communication in a class more directly related to personal awareness. Such a course should be taught by a dance therapist who has had clinical experience.

When discussing dance therapy we should keep in mind that it involves a therapeutic relationship to another human being. Such a relationship demands academic knowledge and self-knowledge; a dance therapist must go through a process of learning on many levels. The use of body awareness, movement response and interaction as the medium for change can call forth strong and primitive emotional responses. A professional dance therapist needs to have begun to deal with these feelings so as to be prepared to handle them for herself as well as with her client. It is for this reason that those who wish to be dance therapists must be open to their own experiences of growth and change. This could involve therapeutic experiences in movement as well as verbal therapy.

Graduate Program

At this time, the terminal degree for dance therapy education is the master's degree. Eventually a doctoral program will evolve. Education on the graduate level is necessary to develop a professional capable of self-directed practice, research and scholarship. A graduate program should screen applicants for movement skills and the ability to meet emotional demands, in addition to the usual academic requirements of a graduate school. Because it takes years of learning and integration to become skilled in the use of movement, these skills must be a prerequisite, while individual academic courses can be made up.

The graduate program needs to be fully thought out with sequential development of knowledge and skills clearly defined. The faculty might include joint appointments with related disciplines in addition to full-time, experienced dance therapists. More than half the course work should be specifically dance therapy work, including courses in the theory and practice of dance therapy, specialization in different populations such as children, geriatrics or the retarded, and administration and research procedures. Closely related to such a program must be a clinical internship supervised by an experienced dance therapist.

It is often advisable that students consider alternatives to graduate school immediately after college. It is possible to have work experiences of all kinds involving human interaction, using movement and dance in varied situations or working under an experienced dance therapist. Peer groups in movement have also proved useful both in learning techniques and in learning about oneself and oneself in relation to others.

Nonacademic Training

The profession is concerned with developing accredited dance therapy curricula. However, it is presently feasible for an individual not to follow the university route and yet be able to become a registered dance therapist.[1] There is real advantage and merit to structured learning experiences. Recognized programs should give assurance of some minimal knowledge and standards to those who hire dance therapists. Yet if an individual can demonstrate a capability in skills and knowledge that meets set standards, that capability is certainly of more consequence than completion of a formal program.

In addition to academic programs, dance therapy training presently exists within clinics, agencies, special schools and institutions led by practicing dance therapists. These training opportunities may multiply as the number of dance therapists able to offer such programs increases. On-the-job experience, similar to an internship, can be invaluable. However, any training program must be planned with great care so that adequate supervision and learning experiences are available to the student. There is a difference between training and education. Opportunities for expanding knowledge must be made available or a student's range of capabilities will be limited.

The paths of knowledge are many, but they all must be tested against *professional criteria*. In order for members of a profession to claim to intervene in people's lives in a way denied to others, that profession must carefully maintain the standards it sets for the protection of the public and its own members.

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[1] The American Dance Therapy Association, Inc., established a structure for a registry of dance therapists in 1971. Standards of training, knowledge and experience are stated and maintained as a prerequisite for acceptance as a "Registered Dance Therapist." This insures a minimal standard of achievement.

Description of a Master's Level In-Service Training Program

Ann F. Lohn

Overview of In-Service Training

Most of the practicing dance therapists today received their training by taking courses and workshops or by volunteering with an established dance therapist in a mental hospital.[1] In this paper, "in-service training" refers to training within a facility where staff are employed to care for and treat the residents or patients.

There are a number of reasons why in-service training continues to flourish: 1) There is a lack of academic programs. 2) Some people feel the field is too young to be confined to a school of thought, a curriculum or a method; they prefer to explore different routes, do their own thinking and find their own solutions. 3) Others find direct application of theory to practice the preferred method of learning. 4) In-service training is cheaper. 5) Some persons do not have mobility to travel to existing academic programs. 6) Others simply do not have access to information about workshops, courses, seminars and conferences.

In light of these reasons, the profession needs in-service training as an alternate route into the profession. People will continue to seek out this mode of learning. The profession needs to guide and support current and potential in-service training resources as well as establishing standards and levels for such training.

There is a definite need to develop *varying levels* of in-service training, each of which must be defined in terms of goals, training duration, supervision, patient population, etc. No documentation of levels of in-service training is presently being done. However, I am acquainted through personal communication with the following areas of training:

1. Apprenticeships or complete training, under the supervision of a working dance therapist, full- or part-time for six months to three years. Very few provide stipends or salary for trainees.
2. Orientation and preparatory work for community volunteers and students wishing to enter the profession, within a mental health facility under the supervision of a working dance therapist.
3. Practicums or internships at the graduate level, full- or part-time for up to ten months, under the supervision of a dance therapist. Very few programs provide stipends.
4. Summer programs under the direction of a working dance therapist. These are usually full-time; few provide salary.
5. Volunteer work without supervision and guidance from someone in the field (self-taught).
6. Orientations and seminars presented by the facility's dance therapist to appropriate staff groups, trainees and community groups.
7. Paraprofessional training open to the facilities' employees and taught by the staff dance therapist.
8. Accommodation of "field placement" and "independent study" students (undergraduates) in part-time in-service training. Sometimes these students work under the supervision of a working dance therapist; others are completely on their own or under the general guidance of a school counselor or professor.

St. Elizabeths' In-Service Training Program

St. Elizabeths' program provides a full-time practicum for selected students enrolled in master's level dance therapy programs. It was designed and is being implemented at the hospital.

The author's intentions in presenting this program are to 1) present a model of in-service training; 2) provide a basis for comparison of alternative in-service training possibilities; 3) provide a design for those persons wishing to implement a program; and 4) attempt to define standards for *one type* of in-service training program.

The Hospital

The training program is offered by the Dance Therapy Section, St. Elizabeths Hospital, Washington, D.C. St. Elizabeths is a federally administered mental hospital funded by the Department of Health, Education and Welfare (DHEW). The hospital is nationally recognized for its training, research and support of innovative programs (it fostered the work of Marian Chace, pioneer in dance therapy). The hospital's resident in-patient population is approximately 3,100, with an out-patient population of approximately 2,800. The hospital is currently undergoing conversion to a community-oriented mental health facility serving the in-patient needs of the four mental health areas of the District of Columbia. In addition, a community mental health center serving the community immediately surrounding the hospital is located on its campus. Within this framework, the hospital practices the "therapeutic community" approach to patient care. About 50 percent of the patient population is diagnosed as schizophrenic. The hospital also has several youth programs, a nationally

[1] A number of prominent dance therapists today can attribute their primary learning and training to their volunteer work with Marian Chace at St. Elizabeths Hospital in Washington, D.C.

known program for treatment of the emotionally disturbed deaf, drug and alcoholic treatment centers and a maximum security facility.

Development of the Program

The Dance Therapy Section (which employs three full-time dance therapists) is placed organizationally under the hospital's "Clinical Support Programs" and reports directly to the assistant superintendent of the hospital. In addition, the Section looks to the Overholser Training and Research Division (OTRD) for support and coordination of its training activities, and constitutes one of its allied programs. The OTRD, in addition to sponsoring major research activities at the hospital, sponsors ten stipended training programs and four nonstipended programs. These include a psychiatric residency program, other medical specialty programs (e.g., ophthalmology and pathology) and nonmedical training programs in the fields of occupational therapy, recreational therapy, dance therapy, social work, clinical psychology, psychodrama, group training, chaplaincy, nursing education and volunteer services. OTRD and the assistant superintendent were of great support to this author in developing a proposal for a dance therapy in-service training program. OTRD, armed with this program proposal and information justifying the program, assumed the responsibility for obtaining stipend resources from DHEW and the Civil Service Commission. This authority was granted; the dance therapy interns do receive stipends. The internship program is in its first year of operation.

Selection of Students and Duration of Program

The internship is designed to provide clinical internships for students enrolled in master's degree programs in the field of dance therapy. The Section contracts yearly with universities to provide full-time internships for a limited number of students. Only students from these universities are eligible for acceptance into the program, which lasts either 5 or 10 months. Currently the Section is authorized to accommodate up to four 10-month interns per year. There are three stipend levels which are dependent upon the student's educational level (i.e., first, second or third year of graduate school) and currently funded at from $5,686 to $6,707 per year. Candidates are nominated by their university program director. The candidates must then submit a standard form (171) for federal employment to OTRD and meet all requirements for Civil Service employment. Because of Civil Service regulations an interview cannot be required; this is an obvious weakness in the application procedure. Final selection of the interns rests with the Dance Therapy Section.

Training Areas

The program is composed of six training areas: orientation, clinical practice, supervision, seminars, course work and record keeping.

Orientation

The orientation phase assumes about 25 percent of the interns' time during the first month of the program. It includes: 1) an orientation to the Dance Therapy Section (its philosophy, methodology and approach to patient care; requirements of the internship; hours and leave approval; record keeping; telephone and equipment usage, etc.), 2) an introduction to the various dance therapy groups currently in process and 3) an orientation to the hospital. The hospital orientation includes a history, information on the catchment areas serviced by the hospital, a tour, a discussion of the "therapeutic community" approach to treatment and an introduction to the various professions found at the hospital. These introductions are presented, if possible, by a representative of each discipline (e.g., social work, music therapy, psychodrama) and include participation in the activity or therapy.

Clinical Practice

The primary task of the internship is to provide clinical practice. This experience at St. Elizabeths is designed to expose each intern to the use of dance therapy with a *wide* range of patient populations, i.e., both in-patient and out-patient (day-care) groups, admissions, chronic patients, geriatric and adolescent groups, and patients with both emotional and physical handicaps (such as the deaf, the blind and those confined to wheelchairs).

The first phase of the interns' clinical practice is gaining an understanding of the current groups being led by the dance therapy staff. This means becoming acquainted with the patients themselves, the wards that the groups are from and each ward's philosophy and treatment plan. This is accomplished by participation in each dance therapy group as a group member, discussion with the leader and selected ward personnel following the group (in what is called the post-group discussion, and attendance at appropriate staff and patients' meetings. The interns do not have responsibility for groups during this phase.

As the interns' readiness develops, portions of sessions are given to them to lead (a form of co-leadership). This co-leadership arrangement with staff continues throughout the internship. No more than one intern works with a staff member in any one group. This arrangement provides the student with a "model," some responsibilities in leadership and experience as a co-leader. Within this framework particular attention is given to methodology, growth of the co-leadership relationship and the relationship of the co-therapy team to the total ward staff and patient situation. As the interns display confidence in assuming responsibilities in this fashion, they are given a choice of several groups not currently receiving dance therapy from which to select and set up their own group. The selection of this group begins anywhere from the third to the seventh week depending upon the interns' readiness. (The selection usually takes a couple of weeks.) This group becomes the sole responsibility of the intern, who selects group membership, establishes goals, works out relationships with ward staff, carries out the therapy (the group meets twice a week if it can be arranged) and handles the termination. The interns in the 5-month program get approximately 3½ months' experience running their own group. Their work is very closely supervised by one of the dance therapy staff members.

In addition, if they are interested and have time two interns may co-lead a group of their own. This includes selecting group members, developing goals, etc., as well as working out the co-leadership of the group. This experience is in addition to each intern's own group and is not a program requirement. It is the author's observation that this experience has been positive for the interns, in providing support to one another in what can be a very anxiety-provoking situation, in learning about oneself in relation to another student (including one's strengths and weaknesses) and in learning how to use this knowledge effectively in a co-leadership arrangement.

If the interns complete a full 10-month program, it is expected that by the sixth month their strengths and preferences as to patient populations will be more definitive. At this point they are encouraged to select an additional group and/or an individual patient with this population specialty in mind. The group may be in either the hospital or the community, but individual work is done only within the hospital setting and is closely supervised by the dance therapy staff.

Post-group discussions form a large part of the clinical practice (see section below on supervision). These occur after each session throughout the training period.

Attendance at appropriate staff meetings, patient meetings and other patient activity groups is encouraged. These provide the intern with useful information about his/her group, provide a continuity of treatment and secure the intern's position as a contributing "team" member. The interns spend about three hours per week in this capacity. It is considered part of their work with patients. All in all, 50 percent of their time is spent in direct patient involvement.

Another experience vital to each intern's clinical training is exposure to lecture/demonstrations. The Dance Therapy Section provides periodic lecture/demonstrations and movement seminars for different groups within the hospital and in the surrounding community as part of its in-service training and community work. Whenever possible, the interns are included in these events, sometimes as group participants, sometimes as co-leaders, dependent, of course, upon the type of group and the intern's preparedness and interest. This aspect of the clinical program helps prepare the student to deal with staff, staff's questions about dance therapy and the eventual responsibility of running in-service training events in their future jobs.

Supervision

Supervision, post-group discussions and the didactic work within the Dance Therapy Section are all closely interrelated. Because the focus at the hospital and within the Section is one of therapeutic community, difficulties and strengths of one individual are many times the appropriate concern of all those in the section. It is for this reason that supervision occurs in more than one context. Supervision takes place following the various staff/intern co-led dance therapy groups during the post-group discussion. The interns also receive one-to-one supervision of their own groups and on varying levels during the seminar discussions and movement sessions. (See section below on seminars.)

It is evident that supervision permeates many of the interns' hospital experiences. The supervisory functions include teaching, administrative and enabling tasks. Specifically, the teaching component involves understanding of methodology and integration of theory with practice. The administrative responsibilities include coordination of the day-to-day activities, seminar planning, policy setting and accountability. The enabling function becomes one of support and encouragement, constructive criticism and facilitation of growth and self-awareness.

Mid-term and final evaluations of the interns' progress and work performance, prepared by the entire dance therapy staff, are shared with the students and then sent to their universities. Each intern also presents an evaluation of the internship to the Dance Therapy Section and forwards it to his university.

Seminars

There are two weekly seminars within the Dance Therapy Section—one verbal and one movement. The two-hour verbal seminar is open-ended. The foci are 1) problems which arise as the work progresses (e.g., adjustment to the hospital, patient/staff relations, difficulties with co-leadership), 2) presentation and discussion of specific didactic areas (e.g., methodology, use of dance therapy in a variety of settings, how to start a group, goals, the varying roles of the dance therapist, termination), and 3) planning, following up, coordinating and integrating the internship experiences.

The two-hour movement session is attended by both staff and interns, as is the verbal seminar. These sessions are experiential, with verbal discussion and applications made following each session. The sessions involve ongoing *intra*disciplinary group experience, dance therapy theories and methodology, movement observation, nonverbal communication, expansion of movement repertoire and leadership experience. Videotaping of the movement sessions was begun in 1973. Total time spent in intradisciplinary seminars and supervision is 20 percent.

Course Work

In addition to the intradisciplinary seminars, St. Elizabeths provides a wealth of opportunities for additional didactic and experiential learning. There are three major sources through which courses and seminars are offered:

1. The Nonmedical Training Branch within the Overholser Training and Research Division (OTRD) sponsors a series of courses called the "Core Curriculum." The courses are offered on a semester basis and include such areas as family therapy, concerns of the aging, clinical psychiatry, human development and research. The courses are open to all students in nonmedical training programs.

2. The Group Training Section within OTRD offers a variety of programs which include didactic seminars, experiential groups and supervised practicums. These programs run September through June and are open to all hospital trainees and staff.

3. The Psychiatric Residency Program within OTRD offers courses in such areas as social psychiatry, child development, family therapy, diagnostic case conferences and psychodynamic therapy and technique. These courses generally run September through June and are offered primarily to the psychiatric residents. However, special permission to take a course through this program can be obtained for other hospital trainees and staff. The Psychiatric Residency Program also sponsors a weekly staff development series called "Grand Rounds." Speakers representing various disciplines, both from within the hospital and from the community, present issues relevant to the mental health field. Attendance at these seminars is open to the entire hospital and the Dance Therapy interns are expected to attend.

The interns are allowed to select no more than two of the above course offerings in addition to attending the Grand Rounds seminars. Attendance at such courses as "Clinical Psychiatry" and the "Basic Hospital Group Work Training Program" have proved very valuable to the interns thus far. This additional course work helps build each intern's special area of interest, fills in areas not covered by their respective university curricula and acquaints the interns with other hospital trainees.

There is also a weekly two-hour course in "Manual Communication" (sign language) available through the Hoffman Division—the division for the treatment of the deaf. The program for the deaf at St. Elizabeths is quite extensive. Since the Dance Therapy Section provides services for this division, it is expected that any intern working with the deaf will choose "Manual Communication" as a course option. Total time spent in lectures and seminars outside the Dance Therapy Section amounts to about 20 percent of the intern's time.

Record Keeping

Each intern is expected to keep an ongoing log or journal which may include observations of various group processes and individual patients' responses, personal reactions to the hospital environment, patients, staff, course work and supervision, insights gained from dance therapy sessions, and observations of personal growth and development. This is a personal journal; interns are not expected to turn it in for review. Names of patients used in the journal must be kept confidential.

In addition, each intern must write a summary monthly report which is shared with the Section and sent to the respective universities. Finally, the interns are required to write "medical records" (progress notes) on each patient in their groups. These are put in the patient's permanent file. Since the life of an intern's group is only three to four months, the medical records are written only once—at the time of termination. In groups where the intern is co-leading, he writes periodic medical records in collaboration with the other group leader. Attendance records are kept on all groups. Record keeping assumes approximately 10 percent of the intern's time.

CRITERIA FOR GRADUATE LEVEL PROGRAMS

While developing the program at St. Elizabeths Hospital, it seemed useful to develop criteria for any graduate level in-service training as general guidelines. The following should be considered:

1. There must be a Registered Dance Therapist[2] at the place of internship.
2. The primary supervisor, who is a Registered Dance Therapist, is responsible for determining when the intern is ready to handle responsibility for patients and for providing close supervision of the intern's work with patient groups.
3. An internship at the graduate level should be coordinated with university requirements. However, it is recommended that training be full time, preferably for 10 months.
4. The interns should experience a wide range of clinical dance therapy experiences (not only variation in types of patient, age, sex, etc., but also variation in group size).
5. Interns should receive a complete orientation to the particular mental health facility (including administrative structure, philosphy and orientations to the various disciplines). There must also be a complete orientation to the dance therapy services themselves (including current groups, wards, goals, particular approaches to dance therapy, etc.).
6. There must be an ongoing dance therapy seminar provided by the dance therapy staff. It can include both verbal and movement content and cover theory, methodology, movement observation, leadership, literature seminars, discussions of record keeping and goals. A minimum of 15 percent of the internship should be devoted to dance therapy seminars.
7. A minimum of 10 percent of the student's time (other than the dance therapy seminars) should be in courses, lectures, case presentations and/or seminars offered at the particular facility.
8. Fifty percent of the student's time should be with patients.
9. There should be mid-term and final evaluations compiled by those persons having major input into the program; these should be shared with the students. The students should also present mid-term and final evaluations of the internship program, both to those having the greatest input into the program and to their universities.

CONCLUSION

These guidelines are offered out of interest in promoting standards. Minimal guidelines for various levels of training should eventually be developed. These would help 1) establish and define various levels of training (i.e., master's, undergraduate, paraprofessional); 2) promote good quality training; 3) provide models both for future development and as standards for interested students and professionals; 4) demonstrate the profession's willingness to assume responsibility for the quality of training. In creating in-service training programs, care should be taken to provide enough experience and supervision to enable the student to meet professional standards.

[2] The American Dance Therapy Association, Inc., established a structure for a registry of dance therapists in 1971. Standards of training, knowledge and experience are stated and maintained as a prerequisite for acceptance as a "Registered Dance Therapist." This insures a minimal standard of achievement.

Dance Therapy in the Community—the Mental Health Consultation Model

Barbara Freudenthal Govine

Statement of the Problem

The stark reality is that in mental health we are not likely to keep up our present number of professional personnel ratio to patient populations . . . One possible solution is to train more personnel. (1)

Ever since the Joint Commission of Mental Illness and Health published its summary findings (1961) there has been increasing consensus among the mental health professions that there is a great need for trained mental health personnel below the professional levels. The final report of the Joint Commission (1962) came to the conclusion that "sufficient professional personnel to eliminate the glaring deficiencies in our care of mental patients will never become available if the present population trend continues without commensurate increases in the recruitment and training of mental health manpower." (6)

In light of the present and projected shortages of mental health workers, this paper proposes that one effective and efficient way to train mental health personnel and provide them with new skills, including those of dance therapy, is to apply the mental health consultation model in their training.

Principles of Mental Health Consultations

The techniques of Mental Health Consultation (MHC) were developed first in Israel and then at Harvard. Originally the concept was devised for psychiatrists, psychologists and psychiatric social workers (consultants) working with teachers or child care workers (consultees). Caplan finds that the techniques are learned fairly quickly by those with training in case work or psychotherapy. He talks about a "consultation process in which the consultant and the consultee are both professionally trained people. The consultee asks for help in regard to mental health problems that concern the consultee's client(s). So three people are actually included, the consultant, the consultee and the client" (2:119).

A crucial phase of establishing an MHC is initiating the consultation contract. Caplan includes the following points in describing this process:

1. Identify the channels of communication for negotiating.
2. Although it is good for the consultant to be based outside the consultee's institution, he should come inside the institution to carry out his work. Only by penetrating the field can he obtain a firsthand impression of the forces impinging on the consultee and get a valid idea of the difficulties he is facing in his work. (2:120)
3. The consultant should define his function so as to leave himself free to focus later sessions as he wishes. He must encourage flexibility and leave the door open for future changes. (2:122)

When discussing the development and maintenance of the consultation contract Caplan makes the additional points that:

1. "The continuing link between the consultee and the consultant is provided by the emotional relationship which is built up between them. This not only motivates the consultee to maintain the contract but is the vehicle for the consultation process itself. To build up the emotional link as quickly as possible and to be constantly aware of its nature is a basic responsibility of the consultant" (2:122).
2. The consultant must be tactful and sensitive to the strain under which the consultee is working. He must not allow the latter's anxiety level to rise too high, as this could be construed as rejection and effectively block the development of a positive relationship. (2:123)

Dr. Dan Feller, mental health educator with the Los Angeles County Department of Health Services, makes further recommendations about establishing a consultation contract(4). He advises a written agreement which includes the number of sessions, the time of day, the day of the week, the location of the sessions and an indication of who will participate. He stresses the importance of reminding the administrator that the consultant's connection to the former's clinic/hospital/school is limited in time and that the consultant is not going to become a permanent part of the administrator's staff.

Mental Health Consultations in Dance Therapy

When establishing an MHC in the specialized area of dance therapy and nonverbal communication skills I have found it effective to include the following stipulations:

1. Consultations will run an average of 10 to 12 weekly sessions.
2. Sessions are to be attended by both patients and staff.
3. Actual sessions are scheduled for one hour, to be immediately followed by a rehash with staff to discuss what has just transpired.

4. The administrator has a standing invitation to observe or participate in any sessions.
5. A specific goal of the consultations is to identify the staff member(s) who will continue sessions in dance therapy once the series of MHC's has been completed.
6. The consultant will make herself available as supervisor/resource person to this target staff member upon completion of the contract.
7. The consultant encourages the target staff member to continue to develop dance therapy skills, to communicate with other dance therapists and to participate in workshops and professional groups.

It is important to point out the significant way in which I have chosen to deviate from the traditional Caplanian model. Caplan would work only with the consultees, never with the patients. I find it important to provide the consultees with modeling behavior in the role of dance therapist; therefore I choose to work with patients as well as staff for a limited time period. My assumption is that my consultees have not had the advantages of specialized clinical training in dance therapy. In addition, I have reflected upon how much I learned from my teacher, Marian Chace, by simply observing her in action with patients and from participating in her sessions and discussing them with her afterwards(3).

Three Examples of MHC's in Dance Therapy

I would like to describe two recent, successful MHC's in dance therapy and one less than successful MHC, and attempt to evaluate the factors that led to their success or failure. I must reemphasize that a major thrust of my role as consultant is to identify and train a staff member of the consultee group to carry on the sessions once the contract has expired. Failure on my part to find such a person, even though I am convinced that the sessions were beneficial and therapeutic for the patient group, would cause me to identify the MHC as a failure.

One consultation was a 12-session contract with the Day Treatment Center of a California state mental hospital. I was approached by a psychiatric technician whose administrator, a psychiatrist, thought dance therapy would be a positive experience for their patients.

The staff member who became the target consultee was a recreation therapist who had a solid background in folk dance, knew some modern dance and had been exposed to dance therapy by another consultant. However, she had never received specific guidance to assist her in conducting dance therapy sessions herself.

Although sessions varied considerably from week to week, some basic principles remained the same. These included:

1. Beginning the sessions with a directed warm-up with the patients in a circle (standing, sitting or lying on the floor).
2. Picking up movements from the patients, focusing first on the periphery (head, hands and feet) and moving towards the center, involving the whole body.
3. Attending to the energy level of the group.
4. Attending to the specific expressions of nonfunctional body tension expressed by members of the group and providing experiences designed to identify and relieve those tensions.
5. Achieving closure through a group movement experience at the end of the session.
6. Facilitating a verbal discussion at the close of the session to deal with the feelings evoked by the experience and provide feedback for both the consultant and the consultees.

Regarding content, I feel it my responsibility to provide the consultees with a smorgasbord of points of departure, stimuli, use of music, use of imagery, use of props, to give them a reservoir to draw upon once the contract sessions are completed. To be more specific, I used a wide variety of ethnic and folk dance recorded material recommended by Genieve Fox, music and dance consultant of the Children's Music Center(5), balloon stick beaters(7), scarves, stretch ropes and artists' plastic drop cloths(8). We explored movement in diads and triads. I attempted to introduce the use of videotape with focused feedback in the last sessions(9).

The patient population in this MHC was predominantly chronic psychotics in the 30- to 50-year-old age group. Many of them were depressed and many were receiving psychotropic medication. Some of the movement experiences were designed primarily to stimulate the patients into activity in contrast to their characteristic psychomotor retardation.

Factors leading to the success of this MHC included the interest and enthusiasm of the recreation therapist and the psychiatric technician and the administrative support provided by the chief psychiatrist. Although the rehash sessions did not match my expectations, they seemed to meet the needs of the consultees, whose ranks also included several nursing trainees.

In contrast to this MHC was an experience with the staff of a pilot residential program for barbiturate detoxification in a rehabilitation facility. The patient population was in the 16-30 age range and in general would be diagnosed as having personality disorders.

The basic principles of dance therapy underlying the sessions remained the same. However, the content differed markedly from the sessions with chronic, psychotic patients. In the drug abuse group I emphasized recorded rock music and some electronic music and attempted to introduce sensory awareness and meditative experiences. In addition, I made greater use of videotapes for feedback to the patients following the sessions.

The contract negotiating was done with a clinical psychologist who had the support of the administrator, a psychiatrist. The target consultee was a recreation therapist who had a strong background in movement experiences and movement sciences. The consultee group included two clinical psychologists, one associate psychologist, two recreation therapists, several members of the nursing staff and on two occasions a medical intern. This contract also ran for 12 sessions.

The rehash sessions generally included all of the above-mentioned consultees and provided an opportunity for a great deal of useful feedback to the consultant. In my opinion the high staff morale and their openness to

innovation in their pilot project contributed greatly to the success of the consultation. A weakness in this MHC was the use of the videotapes, which turned out to be more a general playback than a focused feedback as suggested by Stoller.

I feel the need to describe briefly an MHC which did not prove successful according to my criteria. The institution was a Regional Mental Retardation Center and the patients were severely and profoundly retarded children.

The sessions were clearly beneficial to the patients and in fact some fairly remarkable changes in behavior were noted during the course of the consultation. However, even though the consultees (two psychiatric social workers) participated actively in the sessions, neither of them was interested or had the background in movement to continue the sessions. In retrospect, the original contract was rather fuzzy, and the sessions extended long beyond the limit of 12. It appeared regrettable to me that the Center was not funded to hire a dance therapist on an ongoing basis, as using dance therapy in the consultation model did not prove appropriate in that setting.

Some Future Projections

Returning to my original premise—the need to train personnel to meet the deficiencies in the treatment of mental health patients and in the ratio of patients to staff—it has been my experience that using dance therapy in an MHC model is one way of extending my skills to a wide range of mental health workers and settings. I have also observed that very few mental health practitioners calling themselves dance therapists are indigenous to the racial ghettos and barrios, although movement activities are included in the treatment programs in clinics in these areas. It occurs to me that a registered dance therapist could use the MHC model to establish contracts in ghetto and barrio clinics, carry out time-limited programs and identify the community people working in the clinics who already have dance and movement skills. These community people could be encouraged to continue developing their skills and to communicate with dance therapists through participation in workshops and professional organizations.

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ELIZABETH POLK pioneered creative dance for children in the United States after a successful dance and teaching career in Europe. She has been working with special children since 1957. Mrs. Polk is on the faculty of the Adelphi University (Garden City, New York) dance and physical education departments as well as its Children's Center for Creative Arts. Her records, "Orchestrated Music for Special Children" and "Wake Up—Calm Down, Through Rhythm and Dance," are used widely by teachers and parents.

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ELISSA QUEYQUEP WHITE, D.T.R., is a lecturer and field supervisor of the Dance Therapy Master's Program at Hunter College, New York City and a dance therapist at Bronx State Hospital, New York. She has been involved in dance therapy since 1963 both as a practitioner and as a charter and board member of the American Dance Therapy Association. Mrs. White has published articles on dance therapy theory and the training of dance therapists and has conducted workshops in dance therapy.

PETE WISHER, Ed.D., is director of the Gallaudet College Dance Group. He has served the American Association for Health, Physical Education, and Recreation as Eastern District Dance Chairman, Dance Forms Chairman and Dance Therapy Section Chairman. Mr. Wisher has published numerous articles on dance and has conducted many dance seminars. He has presented papers on dance for the deaf in Stockholm, Paris, Warsaw and Tel Aviv.